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A HOSPITAL WHICH WAS BUILT TO ENDURE

The Rhode Island Hospital Develops on Foundations Laid Down Long Ago—A Home-Like Institution, Durably and Sensibly Built—Some Examples of Economy in Administration

By J. J. WEBER, Associate Director, Boston Dispensary, Boston

ONE cannot nose about the Rhode Island Hospital at Providence, Rhode Island, for the greater part of two days, as I did recently, without coming away with two or three fairly clear-cut impressions: one, that the founders of the hospital were men of great foresight, and they and their successors, good builders; another, that the hospital is run as economically as it can be, consistent with good service; and a third, that a warm, home-like atmosphere pervades the institution in contrast to the cold, forbidding spirit that now and again prevails in hospitals.

After driving from the railroad station to the hospital through a section of the city crowded with homes and factories, one is pleasantly surprised at coming out upon a park-like plot of twenty-eight acres of ground with a group of hospital buildings standing well back from the thoroughfare. The trustees of the hospital were far-sighted in purchasing this large acreage and in

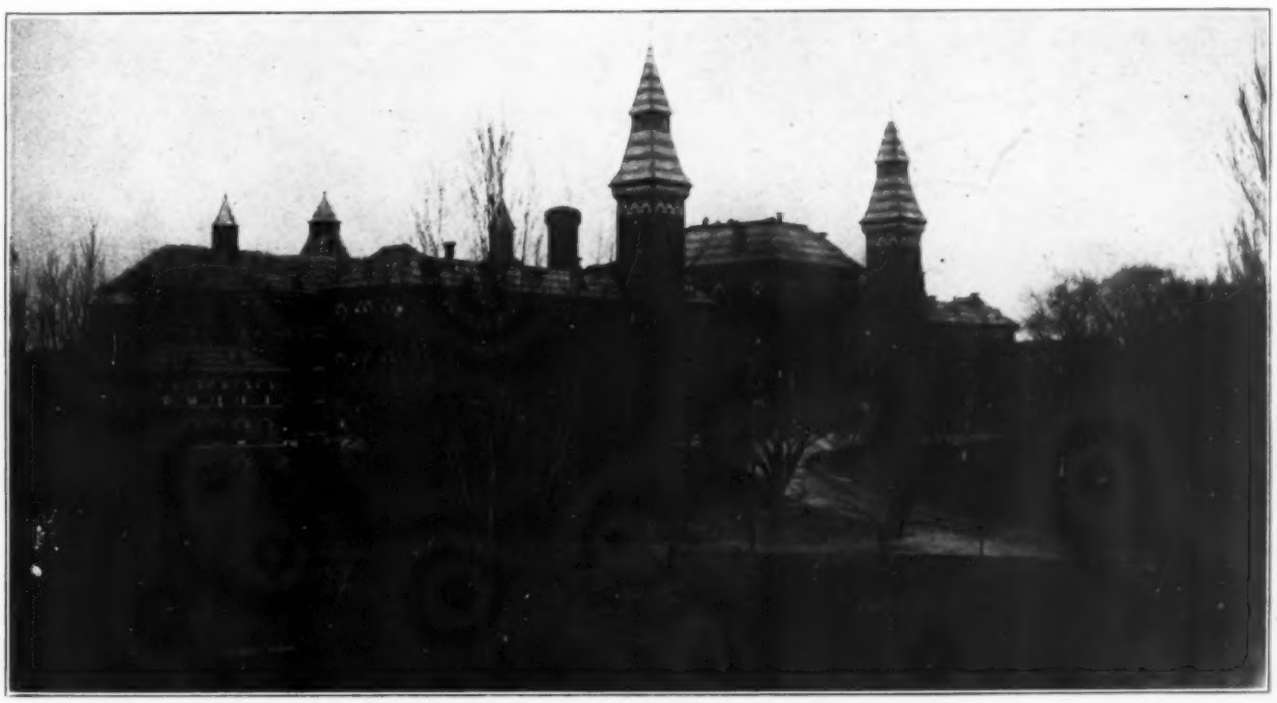


Fig. 1. Rhode Island Hospital, Providence, R. I., a hospital which has endured and grown for fifty years.

subsequently acquiring additional adjacent property. The spacious site gives the institution ample light and air as well as adequate grounds for necessary expansion into a homogeneous group of buildings on a single plot of ground, a condition which through lack of foresight is wanting in many growing hospitals. The Rhode Island Hospital has its own greenhouse where plants and flowers are raised, which later decorate the wards and rooms or fill the flower beds artistically scattered about the grounds.

Not only are the grounds adequate, but the buildings are substantially constructed and the rooms well arranged and equipped. This applies in large measure even to those original buildings



Fig. 2. Where the white work of the hospital is done.

constructed back in 1868. The founders agreed upon a well-thought-out plan for the construction and future growth of the hospital, and the buildings were so constructed as to admit, when necessary, of the expansion of some of their features at slight expense for alterations. This point bears emphasizing because all too often building committees fail for one reason or another to take into consideration future growth. Subsequent buildings, such as the service building, the nurses' home, and the addition to the dispensary, were erected only after prolonged and careful study, during which both the purpose of the buildings and also efficient and economic administration were never lost to sight. Just how much thought was put into planning with an eye to efficient administration and economy of space, labor, and material, becomes apparent to any one visiting the hospital's service building. Whatever side one may have taken on the question of whether or not it is wise to locate a hospital kitchen on any but the ground or basement floor, one must admit that the kitchen of the Rhode Island Hospital, located on the second or top story of the service building, would in itself be difficult to improve upon. The floor space is ample without being excessive, the equipment and accessory rooms complete and so arranged in relation to each other as to insure a minimum number of movements to accomplish desired results and an orderly routing of activities. The floor of the kitchen is Hudson River blue stone. This was chosen because similar stone had stood up under forty-five years of service in the hospital's old kitchen. The hoods over the ranges and caldrons are connected with a flue leading to the hospital's high chimney, around which the service building was constructed, so that they carry off all the odors and practically all the steam. Not only are there windows on two sides of the kitchen, but a chain of sixteen vertical skylight windows give additional light and ventilation. I could not detect the trace of the cooking odors so often found in the kitchens of hospitals and other institutions. A feature worthy of special note is the method of piping the hot and cold water to the caldrons as well as the gas to the stoves. Frequently these pipes are laid under the floor and, when in need of repair, necessitate tearing up the floor, to say nothing of causing the workers to suffer needless back-breaking and to run the danger of being scalded. Here they are fully three feet from the floor and easily accessible when in need of repair. Another interesting feature is a small, well-ventilated drying closet for the dishrags and towels. The cook's stores, two refrigerators, elevator lift, dishwashing rooms, and roasting oven, all lead out from this main kitchen, while a step or two through a corridor brings one to the



Fig. 3. Ready for a sea bath. Patients from "Allen Hospital."



Fig. 4. A few of the family from the infants' ward.

preparation room and the bakery. In the garbage room, the barrels stand on heavy removable wooden racks about a foot from the ground. This arrangement makes it easy to keep the racks and room clean and free from offensive odors. Trucks of a height similar to the racks obviate the necessity of lifting the barrels when they are to be carted away.

Were we to trace this refuse as well as that taken from the various serving rooms, we should find it taken twice a day to a shed back of the laundry where it is carefully inspected by an assistant housekeeper for the purpose of discovering waste, and is then emptied into the larger barrels. The superintendent feels one of the best indices of waste is the refuse barrels; they are watched closely. If food is good, well cooked, and tastefully served, waste will be at a minimum. For its garbage, of which there are three or four barrels a day, the hospital receives a substantial sum each month. This garbage shed is equipped with hot and cold water and hose with which to wash out the barrels and a differential fall for loading them on to the truck. Adjoining the garbage shed is a brick enclosure in which is installed the grate of a discarded boiler set. This is used as an incinerator, where, after an inspection by an official, the refuse is burned each day by its own heat. The general adoption of this plan would save hospitals a measurable part of their gas bills.

The question of food economy in hospitals, as elsewhere, involves three factors. Food must be good, properly cooked, and attractively served. Rhode Island Hospital feels that it has solved the problem as far as the first two factors are concerned. As in many other hospitals, however, the third factor has not been satisfactorily solved, but the Rhode Island Hospital is faithfully working on the problem. Not being satisfied with any of the food trucks on the market for keeping food hot in transit, the Rhode Island Hospital is experimenting with a device built on the principle of a fireless cooker. This is being tried in transporting food to a small group of private rooms. Should it prove satisfactory, larger ones will be built for transmitting food to the large public wards. The plan then is to wheel these trucks into the wards and serve each patient at his bedside. One nurse will wheel in a truck with the dishes, silver-ware, and other accessories, while other nurses serve the food in character and amount as the patients desire.

Adjoining the main kitchen is the diet kitchen, with its own milk and general refrigerators. The unique feature of this room is the shelves along one wall which are so built as to hold the various trays with their legs swung under and held by spring devices until they need to be released and placed on the bed. This buckling under of the legs of the trays also permits of their easy compact transporation in a special truck to the various rooms.

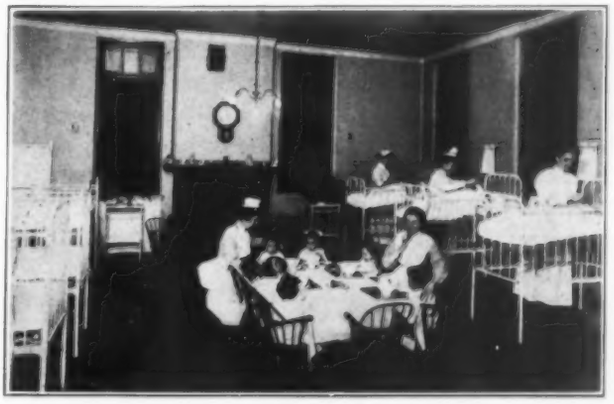


Fig. 5. Five o'clock tea among the babies of the Rhode Island Hospital.

The sewing room with its adjoining clothes and linen room is also on the top floor of the service building. This is a spacious room with two huge cutting tables, 3 feet high and having working surfaces 5 by 9 feet, with three tiers of drawers, each a yard wide. Here are five power machines for sewing and one for darning. This department is a great money-saver, for materials are bought at wholesale when the market is low

and made up into sheets and pillow cases, nightgowns, bandages, towels, and operating-room gowns. Here all the repairing is also done. I noticed a quantity of irregular pieces of cotton lying on one of the tables and, upon inquiry, was informed that these were remnants sent in by the Red Cross. The pieces were large enough to be made into by-products in the form of the sleeves of children's gowns.

Once a week the housekeeper and superintendent of nurses inspects the wards for linen gone astray. But for this inspection, the linen would every now and again get tucked away in some unknown cupboard.

The dining rooms for the doctors, nurses, and employees and their respective serving room occupy the first floor of the service building. The nurses' dining room, which will seat two hundred nurses, is especially attractive. It has windows on three sides and is consequently light and airy. The furniture in these rooms was especially designed at the hospital with a view to making it attractive and at the same time simple in line, comfortable, and substantial—a combination of qualities which the hospital was unable to find in the salesrooms of the furniture dealers. Connected with the dining rooms of both the male and female employees are clothes rooms, where those coming from outside can leave their outer wraps. Each of these rooms is equipped with a washstand and toilet. Each day the superintendent receives from the dietitian the house diet for the day classified for doctors, nurses, help, and wards. In addition to this, there comes to him from each of the dining rooms—employees' dining rooms as well as those of the various wards—little slips listing what was served at the three meals of the previous day with any comments or criticism. These are filed in a scrap book for possible future reference.

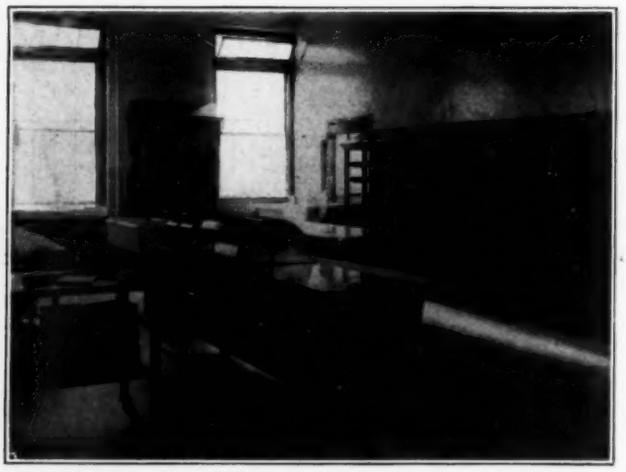


Fig. 6. A corner of the shining, efficient room where the cooking is done.

Although the basement of the service[1] building is devoted wholly to storerooms (marvels of their kind in neatness and arrangement) the Rhode Island Hospital rents space from the Merchant's Warehouse and Cold Storage Company for the storage of eggs, butter, poultry, etc., which it buys from time to time in large quantities. When, for example, eggs are ample and cheap in April, the hospital buys a carload lot, places them in storage, and begins to use them for cooking purposes in August when the price has gone up. They are drawn from storage twice a week, and each egg is candled at the hospital before it is sent to the kitchen or the wards. Fruits and vegetables bought when the market is low are canned. When I visited the hospital, 30,000 pounds of canned goods were resting on the shelves of the storeroom. For the soap storage and drying room the hospital selected a room through which ran the smoke flue leading to the chimney. This room is especially warm and adapted to the drying out of soap—a big money-saving process.

The hospital's general repair shop, where many home-made devices are conceived and manufactured by the chief engineer, an inventive genius, is a great money-saver. From all over the hospital there come to this spacious room scores of articles, all properly marked for identification, needing to be repaired, altered, or painted. The nurses are instructed to send articles to the repair shop at the first indication of need of repair, observing the principle that "a stitch in time saves nine." Several men skilled in carpentry, plumbing, painting, and masonry are kept steadily at work here and in and about the hospital. Twice a week the faucets throughout the hospital are inspected and when necessary adjusted and repaired. Every Monday one of the men makes the rounds of the hospital building and looks after the fire pails, extinguishers, and axes, and winds and regulates some sixty clocks.

The hospital has a splendid suite of five operating rooms with their accessory rooms on the top floor of the main administration building. The feature that interested me most in this connection was the special rooms with three or four beds, off the surgical wards, where special patients are brought after operation. They remain here from three to five days under the supervision of nurses who devote themselves exclusively to these patients before they are returned to the wards proper. This arrangement keeps the ward patients from being subjected to the odor of

1. The service building of the Rhode Island Hospital is described in detail in an article by Warren C. Hill in THE MODERN HOSPITAL, February, 1919, p. 85.

ether and gives all patients who have been operated on the watchful care of a nurse not distracted by other duties.

This article would not be complete without some reference to the children's ward. Here were some seventy children, many of them strapped on curved frames, but all happy as could be. Surely if a man had the blues, a visit to this ward would drive them helter-skelter. The hospital employs a full-time teacher who teaches the various grade lessons; most of the pupils when discharged from the hospital are able to keep up with their grades in school, and some do even better than the well children out in the community. When I was at the hospital, a large American flag was being hung in the ward, to be unfurled at an appropriate time during the singing of one of the children's Christmas songs. While I was visiting the ward, the children sang several of the popular Christmas songs with a spirit and vim that would do credit to a group of lusty children, and several of the little ones spoke short pieces relating to Christmas and the coming of Santa Claus. During the summer, many of these children are transferred to the hospital's summer home for children.

Toward the close of my visit and after we had gone the rounds of the hospital, the superintendent led me down a stairway leading off the main waiting room into the basement, into a suite of rooms which was at one time devoted to storage. It is now the lounging room used by the interns, mainly at night. Here is a large, long room, with a piano, billiard table, phonograph, books, magazines, comfortable chairs, and couches. The walls are covered with groups of pictures of former interns. Everything looks cosy, comfortable and den-like—the sort of place where a group of men can feel altogether at home. In a small, adjacent room, which serves as a combination kitchen and dining room, is a center table, a sideboard full of dishes, and a small gas stove. Every evening one of the maids brings in a supply of eggs, bread, milk, coffee, and tea, and the men, when their services are not needed in the wards, gather here for a midnight lunch, a smoke, and a game of billiards. Here they are away from everyone and can make as much noise as they like without running the risk of disturbing anyone else in the hospital.

Like most other hospitals, Rhode Island Hospital is usually not without a deficit each year. To help in meeting these annual deficits, this scheme has been adopted: each year four to five thousand letters are sent throughout Rhode Island to people of means asking them to underwrite any possible deficit at the end of the year up to one hundred dollars with the understanding that, having entered upon this obligation, they will not be asked for any further contributions. This scheme was started many years ago and now the hospital has a body of men who agree each year to meet any deficit up to one hundred dollars. Since 1910 and up to the present year the full one hundred dollars has been called for. But this year only $67.35 per share was asked for. Not only has this scheme an immediate practical value in meeting the annual deficits, but, since the hospital is kept before a group of three or four thousand people every year, many of the men and women appealed to are bound to remember the hospital when they make their wills. Another plan for increasing the income of the hospital, which, however, is not new, is that of establishing free beds. Anyone by making a payment of $4,000 may establish a free bed. Few of these beds are used by the donors the year round and the contributions are usually clear gain. The hospital now has 178 free beds.



Fig. 7. "Washing up" in the nursery of the Rhode Island Hospital.

The Process in Salvaging Used Gauze at Lakeside Hospital, Cleveland

The gauze to be washed is collected from the wards in net bags and placed in the washer about 3 p. m. It is given first five cold-water rinses. It is then left to stand over night in lukewarm water in the washer. Two quarts of soda and one quart of bleach are added to the water. The bleach is composed of 30 gallons of water, 15 pounds of soda, and 10 pounds of chloride lime. This water is then drained, and from 3 to 4 inches of hot water are run in with soda and soap for twenty minutes and discharged. Then from 3 to 4 inches of hot water are run in with two quarts of the bleach. This is boiled for fifteen minutes and discharged. About 8 inches of hot water are then run in, a substitute for oxalic acid is added, and the whole boiled ten minutes. Two cold waters are then run in.

The gauze is then sterilized in the large autoclave before it is handled in any way.

A SUGGESTION FOR THE PRACTICAL TRAINING OF PUBLIC HEALTH NURSES

Public Health Nursing to Be a Part of Municipal Health Service—Cooperation with Training Schools—Emphasis on Child Hygiene and Preventable Disease—Value and Practicability of the Plan

By CARL E. McCOMBS, M.D., Chief of the Division of Public Health of the New York Bureau of Municipal Research, New York City

DURING the past six years the New York Bureau of Municipal Research has made studies of municipal health service in about twenty large cities of the United States and Canada, and in none of these cities has there been found a fully adequate public health nursing service. That there is generally throughout the country, and particularly in our large municipalities, a broad field of opportunity for public health nurses is indicated in a recent report by Franz Schneider, Jr., formerly sanitarian of the Russell Sage Foundation, on "A Survey of the Activities of Municipal Health Departments in the United States." Mr. Schneider points out that of the 163 cities included in his survey over one-half had no proper organization for combating infant mortality and less than one-quarter a coherent program against tuberculosis—two fields of service in which public health nurses have clearly demonstrated their usefulness.

There are many cities of more than fifty thousand inhabitants in which no public health nursing service whatever is provided either by the local health authorities or by private agencies, although many of these cities are in dire need of effective work for the prevention of infant mortality and tuberculosis. In many other cities public health nursing service is available to the municipal authorities only through the cooperation of private visiting nursing or social service agencies, and the fact that the most efficient public health nursing requires that the official health authority, i. e., the municipal health department, shall have the direction of nursing work makes such cooperative relationships relatively unsatisfactory. As Dr. C. E. Terry, who has written so much and done so much to promote public health nursing, says: "We must bear in mind that the time is coming if indeed it has not already arrived when this (i. e., public health nursing) should be distinctly a municipal function. The days of experiment are past and private nursing agencies have no longer a place in any community where due recognition is given to modern methods of health conservation."

If we accept the dictum that public health nursing is truly a function of municipal health service, and that to be most effective it should be completely under the direction and supervision of the municipal health authority, the problem of providing properly trained nurses for such service is one of considerable importance. Every municipal health officer who has had experience in the development of a public health nursing service knows how difficult it is to secure nurses who are adequately trained and otherwise fitted for such service. Dr. George W. Goler, health officer of Rochester, N. Y., one of the ablest and most progressive health officers in this country, says with reference to his own nursing service: "The training of the nurse in infectious disease work has been generally so bad that when nurses come to work for us at the health bureau the first thing we do is to try to get them to cast off all the old notions of infectious diseases that they have gathered from their former teaching." The opinion of Dr. Goler is simply an echo of opinions voiced by many other municipal health officers.

One health officer in a city of over four hundred thousand population stated that he had found the so-called "practical nurses" more efficient for his nursing service than the majority of trained nurses because they had so much less to forget and were quicker in adjusting themselves to home visiting work. From evidence obtained by study of municipal public health work, and from the statements of progressive health officers, it seems quite certain that more practical public health work for nurses in training schools is desirable. Of course, the nurse who can afford to attend post-graduate courses in public health nursing before entering public health service, should do so by all means, but even post-graduate courses in public health nursing do not provide that practical training which is so essential. Besides, there are many nurses who cannot afford to continue their training in post-graduate schools.

The National Organization for Public Health Nursing, which has been a leader in urging more practical training in public health for nurses, has made, through its committee on public health nursing, some excellent suggestions for broadening the curriculum of training schools for nurses and some of these suggestions have already been adopted by such schools. Many training schools for nurses are now affiliated with social service agencies and private nursing associations, and

provision has been made for the practical training of some, at least, of the students of the training schools. But there is still another field for practical training to which little attention has as yet been given—namely, municipal health departments—and the purpose of this paper is to suggest a closer affiliation for mutual advantage between municipal health departments and nurses' training schools.

Before discussing the difficulties of working out a satisfactory plan of cooperation between the hospital training school and the municipal health department, let us consider some of the reasons why such cooperation is desirable. Practical training for nurses desiring to enter public health service is admittedly necessary—but is not practical training in public health desirable, even necessary, for *all* nurses? Every day and in every possible manner the importance of public health work in conserving our national resources is being impressed upon us. The wonderful progress made in public health by our nation in war has opened our eyes to the necessity of more effective health conservation in peace. People are more interested in health than ever before, and hand in hand with this growing interest goes education to teach citizens how to form intelligent judgments in health matters. The nurse in private practice finds that her patients and the members of their families expect her to know more about public health. She is called upon to answer all manner of questions about communicable diseases, prevention of infant mortality, home sanitation and personal hygiene, and, to answer such questions satisfactorily, she must have at least a working knowledge of public health procedures. This she can secure only through actual personal experience.

It would of course be to the great advantage of the nurse wishing to enter public health service to have first-hand knowledge of its aims, its methods, and its rewards. If she is given some practical experience under the direction of the health authority of the community, she will have an opportunity to find herself and to determine for herself whether or not she is fitted for the work. Not all nurses who go into public health service are fitted for it, for it requires, in addition to thorough training, tact, clear judgment, sound common sense, and that indefinable attribute we call "personality." The nurse must be physically fit in every sense of the word; she must be able to elicit the cooperation of those with whom she comes in contact; she must love children and know how to "handle" them; she must be sympathetic and patient in dealing with those who depend upon her for help; and she must have initiative and energy in bringing about the desired result. In short, she must have the faculty of dealing with people as persons rather than as "cases." Under the direction of a competent public health officer, her capability for public health work could be measured and appraised. If she is unfitted for public health work, it is desirable that she know it before she goes into it, so that her future work in the training school may be directed along other lines.

Finally, such an arrangement would be extremely valuable in raising the standard of municipal health service by making it possible for many health departments to obtain service which they are not now able to provide. Other municipal health departments, now inadequately supplied with nurses, could be provided with more nurses at low cost. If proper cooperation with training schools for nurses were effected, municipal health departments should of course assume the responsibility of paying the nurses in training salaries equal, at least, to the stipends which they receive as pupil nurses in the hospital training schools. Furthermore, municipal health departments would gain in efficiency by the very fact of becoming teaching agencies. Just as the teaching hospitals are more efficient than non-teaching hospitals, so teaching health departments would be more efficient than non-teaching health departments.

As to the difficulties in the way of working out a satisfactory plan of cooperation between the training schools for nurses and municipal health departments, two only appear important. The first is that the training schools might have considerable difficulty in adjusting their curriculums so that all nurses in training could receive practical experience in municipal health service, for with the ever growing volume of medical and nursing lore, training schools are already finding the period of training too short. But the importance of practical training in public health work is so great that it is believed other and less important features of training might be curtailed to meet public health needs. If necessary the course of training could, of course, be lengthened, and this is already being considered in many training schools. The second difficulty is that unless the cooperative relationship between the training schools and the municipal health departments were developed with great care, there might be a tendency on the part of municipal health departments, in their desire to get their work done, to exploit the nurses assigned to them. Some training school superintendents have expressed fears on this score, but knowing how willingly and sincerely municipal health authori-

ties cooperate in all that makes for public health progress, it is believed that this danger is more imaginary than real.

The length of the course of practical training in municipal health work would, of course, be dependent largely upon the extent of the development of municipal health service with which the training school had cooperation. Under any circumstances, it certainly should not be less than three months.

In a large municipal department of health such as that of the city of New York, where health service is perhaps more highly specialized than that of any other city of this country, a six months' course would be none too long. In a smaller city, where the services demanded are not so varied or extensive, three months would perhaps be adequate. Let us consider for a moment what such a course of training should embrace in a large municipal health department, such as that of New York City.

The two broad fields of work in which public health nurses are most useful are child hygiene and preventable diseases. In child hygiene a nurse should have practical training in prenatal home visiting and the instruction of expectant mothers; in infant clinics; in midwife inspection and education; in the health supervision of children in schools, in the home, and in institutions. In preventable disease work the nurse should have experience in the home visiting and investigation of cases of communicable disease, particularly tuberculosis and typhoid fever; in clinics for tuberculosis, venereal diseases, and industrial diseases. If possible, other features of health work, such as food inspection, sanitary inspection, etc., should be included in her training, but this experience could be made incidental to her work in child hygiene and preventable diseases. The nurse who goes about her work with her eyes open soon develops the faculty of observing conditions not strictly within her own field and the value of her work increases as her public health vision broadens.

The suggestion which is made in this paper is a suggestion only. If it does no more than provoke discussion among training school authorities and public health officials it will have fulfilled its immediate purpose, for from such discussion, it is believed, would be crystallized out a more definite plan for practical public health training for all nurses.

SPECIAL PROBLEMS OF HOSPITAL ADMINISTRATION

Relation of Staff and Superintendent—No Member of Staff Should Be on Administrative Board—Medical Responsibility of Superintendent Depends on His Professional Training

By HERBERT O. COLLINS, M.D., Superintendent, Winnipeg General Hospital, Winnipeg, Man.

COOPERATION between the administrative and the medical staffs is ably discussed in the article following. How far the two may work together and not trespass upon the functions of each other is clearly defined by Dr. Collins.

EDITORS.

WHAT PART SHOULD THE STAFF MEMBER HAVE IN THE ADMINISTRATIVE ACTIVITIES OF THE INSTITUTION?

The problems of administration are so different from those encountered in connection with the clinical work, and are often so little appreciated by members of the staff, that in most cases it will be found best to draw a sharp line of separation between the two. As no self-respecting member of the staff would tolerate for a moment any interference on the part of the administration with his free judgment of the proper treatment of a case, so he should willingly refrain from the slightest act or word which could be construed as an effort to dictate administrative policies, or which might embarrass the administration in any way in the enforcement of order and discipline.

Nothing tends more surely to cause friction and unpleasant complications than membership of one or more of the staff on the administrative board of a hospital. No matter how careful or tactful such a staff member may be, jealousies on the part of other members of the staff are sure to arise, and the board member will be accused, often unjustly, of taking advantage of his administrative authority to gain for himself or his patients privileges not accorded to others. The one-man hospital is usually a deformed and crippled institution.

This is by no means to be interpreted as meaning that the staff should take no interest in the administration. On the contrary, it should be invited to take considerable interest, just as the administration should keep in close touch with the clinical side of hospital affairs. In no other way can we expect that sympathetic cooperation

so necessary to success. It will be found of distinct advantage to have a committee appointed to represent the views of the staff on administration matters. This committee should be frequently consulted, especially as to needs of the hospital and policies to be adopted. But the communications of such a committee should be understood as advisory only and in no way binding upon those charged with administrative responsibilities.

HOW FAR IS THE SUPERINTENDENT RESPONSIBLE FOR THE MEDICAL SERVICE IN THE HOSPITAL?

The responsibility of the superintendent for the medical service in the hospital is directly proportional to his authority over the staff.

If he appoints staff members, or if they are appointed by the board on the superintendent's nomination, and subject to removal or suspension by him, his responsibility for the general character of the service rendered is very great. If he has no power of appointment or removal, he should be considered as largely free from such responsibility. For even though it may be made his duty to report to a board any evidence of failure on the part of a staff member to give proper service, the superintendent can hardly be expected to act in such a rôle except in extreme cases.

If he be the right kind of a superintendent, there should be no hesitation in placing upon him full responsibility for the maintenance of the proper professional standards of the hospital, providing he is also given the necessary authority to justify it.

If the superintendent is not a physician, but a nurse or a layman, only friction will result from any attempt to hold him or her responsible for the character of the medical service, except in extreme cases. The superintendent who would see patients in his hospital grossly neglected or receiving treatment in any way below the standard, and fail to take such action as may be within his power to correct the evil, would be guilty of neglect in properly protecting his institutions' reputation and the interest of the patients committed to its care. But he can hardly afford to place himself in the position of a bearer of tales for the board, without his being constantly placed in a very undesirable light.

If the superintendent be a physician, he should be given such powers as will justify him in assuming considerable control over the medical service. In fact, under these conditions, he should be held responsible for its general character, just as he is for any other service in the hospital. He cannot be expected to interfere with the details of treatment and will need to be very diplomatic in exercising his authority. But the consideration of the broader questions involved, for the general tone of the medical service, for the enforcement of the recognized principles of medical ethics, the medical superintendent should be held responsible with full authority and power.

The work of the medical staff can not be held up to standard unless it receives the full and intelligent and sympathetic support of the superintendent. Hence, he has duties and obligations to assume, as well as authority. He should consider himself largely personally responsible, in so far as the means of his hospital permit, for seeing that the medical staff is furnished with the equipment and supplies required by them, and that the nursing and other service of the hospital are adequate to give the staff the necessary support in their work. Frequent consultations with the members of the staff, or with a committee representing it, if the staff be a large one, will enable him to keep in close touch with its needs, to cooperate intelligently with those who are doing the clinical work, and will also tend to avoid criticism on the part of the staff members by giving them a chance to become familiar with the problems of administration, and to know the reasons for failure, at times, to grant their requests.

SHOULD THERE BE DEFINITE RULES FOR THE GOVERNMENT OF THE HOSPITAL?

There can be no question as to the advantage of definite rules governing the most important points in the administration of the hospital. Otherwise there will be no order or cooperation, nor any fixed methods of doing things. But such rules, if we are to refer to fixed and established regulations, probably contained in a book of rules, will be better if limited to the most important matters, and should not attempt to go into details too much because of the ever-changing conditions which make it desirable to change methods and rules to meet different situations as they develop.

Such printed rules as may be adopted will be best if they are outlined by the heads of the departments most affected. In order to prevent duplication or conflicting orders, however, it will be best to have all rules and standing orders issued directly from the office of the superintendent. The more important rules, especially those affecting the general policies of the hospital, should also be approved by the governing board.

Somewhere or other in the worst flood of trouble there always is a dry spot for contentment to get its foot on; and if there were not, it would learn to swim.

THE WINCHESTER HOSPITAL, WINCHESTER, MASS., MEETS SPECIAL NEEDS

Problems of Small, Semi-Public Community Hospital Met—Hospital Built With an Eye to Economy and Future Extensions

By WARREN C. HILL, Kendall Taylor Co., Architects, Boston

A GROUP of well-known men, collaborators on the subject of hospital standardization, have referred to the small, semi-public community hospital as one of the most important types of the many different sorts of hospitals which they have had before them for consideration.

The producers of this hospital heartily agree with them; it comes under this classification, and the accompanying drawings and photographs are presented, not as the last word in this sort of hospital construction but as a rather interesting solution of the problem, one which is working out well after two years' trial.



Fig. 1. Main building of the Winchester Hospital, Winchester, Mass.

The town in which this hospital is located lies nine miles north of Boston and has a population of about fourteen hundred. The community is almost wholly residential with but few industries. The per capita wealth is higher than the average, although there are, of course, some of those whom "we have always with us."

The Winchester Visiting Nurses' Association was organized in 1899 and incorporated in 1906 by eleven public-spirited and philanthropic women for the purpose of giving the sick, especially those of limited means, the best home nursing possible and of developing this work along appropriate lines, with a view of ultimately establishing a hospital if the need should arise.

The objects for which the association was started have been consistently and persistently carried on, and the social-service phase of the association work, operated from rooms in the central portion of the town, not from the hospital, is worthy of more than passing mention but is perhaps apart from the subject at hand.

The original hospital was established in an old mansion in March, 1912, with some measure of doubt as to its permanency. The results so exceeded the fondest expectations that within two years the inadequacy of the quarters was so apparent that a campaign for funds for a permanent building was started, which met with a measurable degree of success.

To the trustees and their building committee, all women, this venture was, as is quite usual in such cases, their first hospital experience, but every one of them had an appreciation of her limitation in this respect and, on account of it, learned the quicker from whatever sources information was obtainable. Furthermore, these women did not prejudice themselves greatly by too much visiting of other hospitals—an unusual point to be noted.

The first consideration, after sufficient funds were available, was, of course, the selection of a site, one reasonably accessible yet sufficiently remote from highways with trolley cars or heavy traffic. By process of elimination a splendid location was decided upon, about a mile from the town center, not far from the street cars, and consisting of nearly five acres of high land sloping easily to the west and southwest, fairly well-



Fig. 2. The operating room is finished in ivory enamel on woodwork with French-gray walls and ceilings. A separate ventilating system is used.

wooded for protection purposes, and with excellent, well-drained soil. It might be remarked that the trustees did not purchase the land until the architects had been consulted and reviewed carefully its good or bad features.

This particular type of hospital plan was selected with the expectation that it would care for local people only and not all of these, as the town is close to Boston with its many great hospitals. All the surrounding towns have hospitals of their own and a few patients were expected from them.

Fortunately, the plan was carefully studied for double its capacity, and the plans presented with this paper are the result of a boiling-down process, entered upon to bring the cost of the hospital within the available funds. When the time comes extensions can be made with a minimum interruption to the work in the manner indicated on the block plan.

For topographical reasons the building was placed on the northerly end of the lot, a location which permits of extension south as well as east.

The nurses' home faces the principal street of the four surrounding the lot and is sufficiently removed for all purposes. Later this building will be briefly touched upon.

The type of plan determined, the next step was to decide whether a fireproof building could be built. The architects so strongly urged this that the trustees finally postponed construction for a year in order to raise more money, not for the purpose alone, but in order to build a separate home for the nurses, a feature which was also recommended by the architects.

The bed capacity was a matter of judgment rather than of determination by statistics, and a maximum of forty was finally considered by the trustees and the visiting staff as sufficient. Subsequent events have demonstrated this to be about right for all services except the obstetrical; here the patronage has been so great as almost to overrun the building. It will be seen that Winchester is a growing town and a provision for this growth must be made very soon.

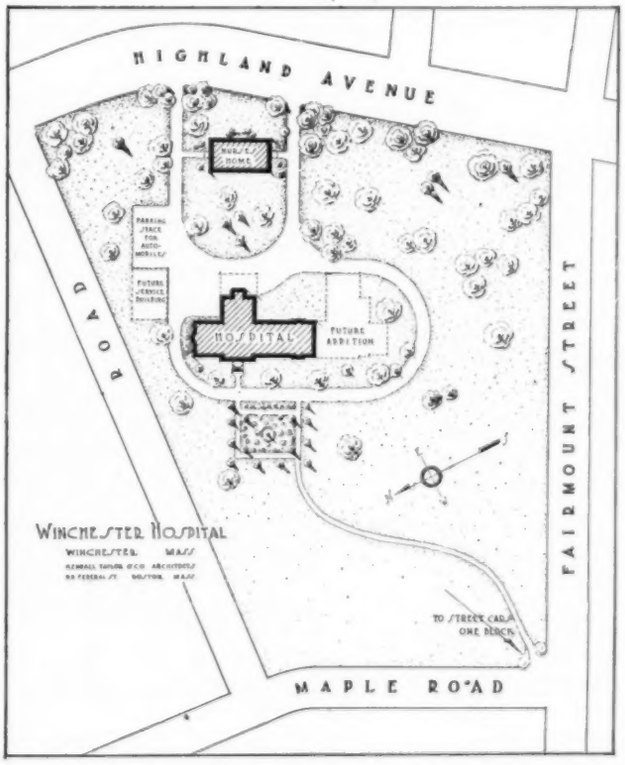


Fig. 2. Block plan of the Winchester Hospital.



Fig. 4. Nurses' home of the Winchester Hospital.

It might be stated in passing that the architects have for several years past had difficulty in persuading some of their clients of this established fact:—Provide more than adequate maternity accommodations and in three years' time—assuming your institution is a success—you will have a waiting list larger than a popular club and have to put out the "S. R. O." sign, as the theatrical people do.

The necessity of providing as much for the money as possible, "and then some," unfortunately required the placing of the boiler room and laundry within the building. This is never a good plan and can be excused only for the reasons given and because it is hoped that these utilities may be placed in a separate building to the north, as soon as it is possible to do so. This building will also contain rooms for female domestics in its upper floors.

The space these now occupy will then be used for an x-ray department and adequate laboratories—the hospital does no x-ray work at present (remember, if you will, the contiguity to Boston) and the provisions for laboratories are not very large for similar reasons. The room marked "laboratory" will then be used for a receiving room for occasional accident cases.

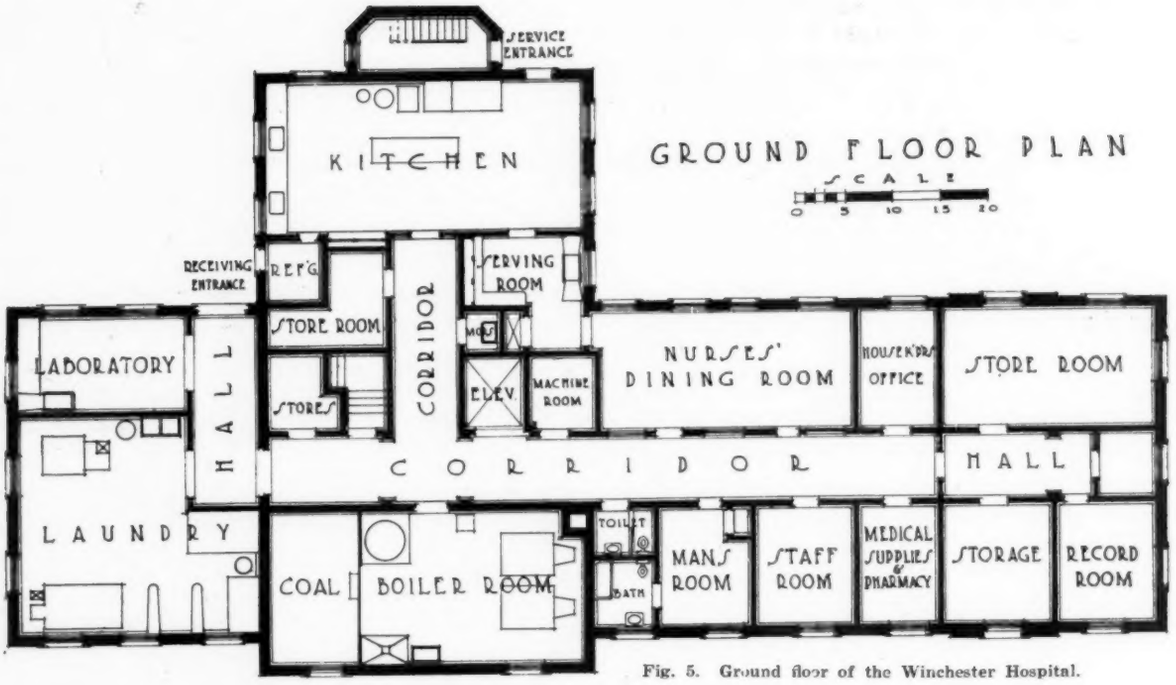


Fig. 5. Ground floor of the Winchester Hospital.

The kitchen is adequate for the present, and further capacity and additional pantry space and a domestics' dining room will be provided when the time comes to extend to the east of this portion of the structure.

A peculiar but very desirable requirement of the Massachusetts district police, who must approve the plans for buildings of this character, is a covered staircase or fire escape at or very close to the extreme end of any wing, in addition to any central staircase that may be provided. This explains the staircase tower adjacent to the kitchen and the one taking a section of the solarium on the south end of the first and second floors. One staircase opens directly on the ground and the other on a platform with steps to grade.

These staircases are skeletonized and bolted together, so that when the time comes for extension in either direction, they can be used again. It will be necessary only to change their location.

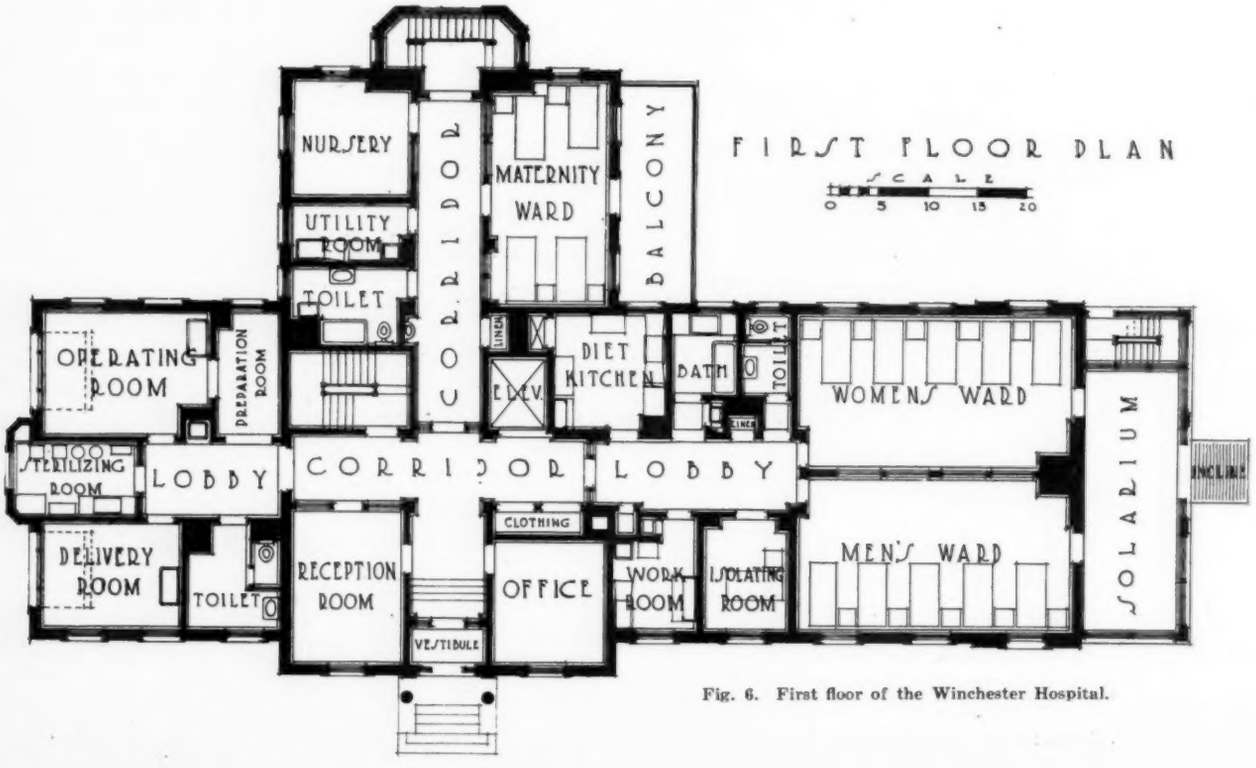


Fig. 6. First floor of the Winchester Hospital.



The housekeeper's office is well located, as actual use has shown; tradesmen use the service or kitchen entrance door for most of their deliveries, and the larger consignments, such as cased goods, can be taken directly into the storeroom through one of the openings.

The staff room is located as it is, simply because there was no other place for it, and, as all the physicians approach from Highland avenue and use the receiving entrance door, this room is very convenient for them. The room has been very tastefully furnished and is much liked.

A glance at the first-floor plan suggests a compactness akin to suffocation until one has made a visit to the hospital, when such an impression is dispelled. It was not possible to place the operating department any place except where it is shown; some day it can be relocated on the second floor directly overhead, or the same space in the second floor can handle maternity work exclusively. No complaint of the arrangement as it is has been made by staff or nurses, and, in spite of expectation, the delivery room in this position has not so far been found in the way.

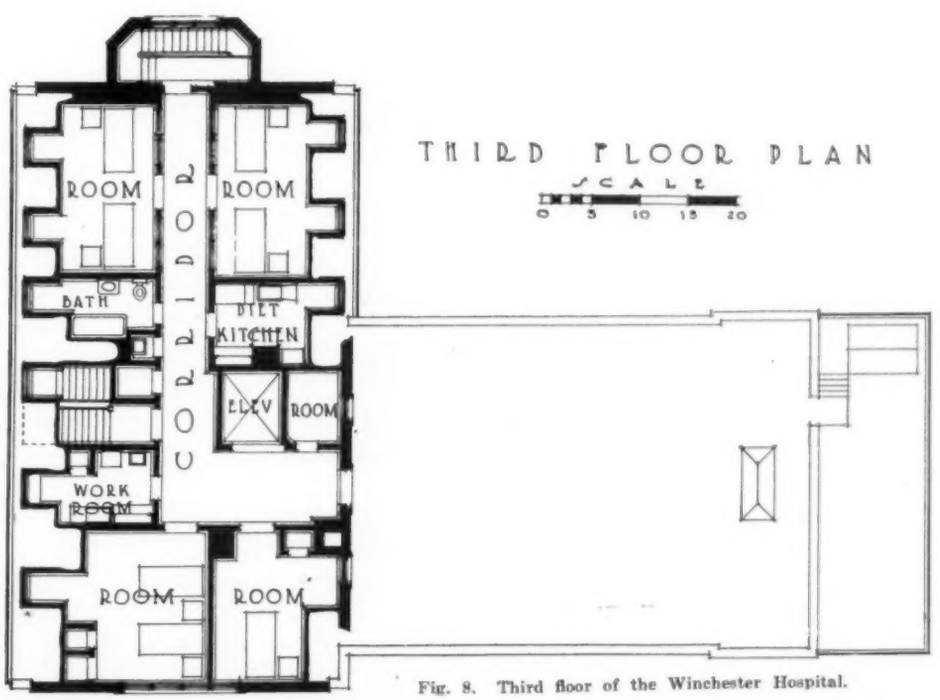


Fig. 8. Third floor of the Winchester Hospital.

The administration portions are adequate for all present purposes, but some time when extensions are made and the workroom is placed in a position more nearly central to the new arrangements, this room and the isolation room too will be made a part of the former by closing the corridor doors and cutting-in communicating doors. The rear or east portion of the main building was originally designed for children, but the children of Winchester somehow seem particularly well and free from accidents, so it is used for maternity ward service.

The duplex ward at the south for medical and surgical service was adopted from necessity rather than from choice; the rooms are cheerful and always filled, the sash in the dividing portion adds to the cheerfulness of the "off side" when the sun is in the east and vice versa, and the use of a sun room in common by both sexes appears to have advantages rather than otherwise. An incline (it looks like a ship's gangplank) permits of easy access to the pleasant grounds adjacent.

It might as well be admitted that one toilet has its disadvantages and that two should have been provided. The construction is so designed that the dividing partition between wards can be removed to allow the corridor to continue on to the extensions when these are made.

The second floor has, beside the private rooms, two two-bed rooms; the portion to the right is reserved for medical and surgical service, and that to the rear, for private obstetrical service. This floor, on the whole, is successful; that is, if popularity means anything. People who might be expected to go to Boston to the larger hospitals prefer the quiet of these rooms with their delightful views to a degree that could not be anticipated before building. If the architects were planning this or another similar hospital in the future, they would be more insistent upon rooms slightly larger, with lavatories in each; and, of course, private toilets would be desirable.



Fig. 9. One of the duplex wards. The sash in the dividing portion adds to the cheerfulness of the "off side" when the sun is in the east and vice versa.

The third floor is surprisingly cool in summer and the rooms much desired; they are used either as single or double rooms. These rooms, originally intended to allow for overflow, have been occupied all the time since the opening. Undeveloped possibilities for out-of-door treatment or recreation present themselves in the flat roof over the wing.

The wood trim—what there is of it—and the doors are of birch, stained a pleasing tobacco brown, except in the operating department, and the varnish is rubbed. In the operating department an ivory enamel was used on the woodwork, with French gray walls and ceilings. All the rooms for patients, including wards and nursery, are painted a gray of lighter shade; buff was used elsewhere throughout the building.

The floors and bases in the kitchen and serving room are of red tile; the toilets, baths, workrooms, operating department, etc. are of white marble terrazzo; all corridors, rooms, and ward floors are of battleship linoleum, green in color. Other floors are of granolithic, and the bases, where there are linoleum floors, are of the same material run up 6 inches on and flush with the walls, coved out onto the floor 3 inches, and are painted green to match the linoleum. The effect is very pleasing.

The plumbing is of the best, and no expense has been spared here. There are no special features other than the wall-hanging water closets which keep the floor under them clear and the specially designed elbow-action valve on the surgeons' sinks. Sterile water is run through lead-lined piping direct to the sinks in the delivery and operating room from a gravity storage tank. In the bathrooms a conservatory arrangement for storing and watering cut flowers is found very convenient and keeps this well-known difficulty well in hand.

Heating is by direct steam. Ventilation for all rooms is provided, separate from the toilets and similar rooms. The ventilation of the operating department is also separate from all other rooms; this room has a small fan over the third-floor ceiling space with a remote control switch in the operating department corridor. The architects thoroughly believe in window control for air changes in a building of this class for all rooms occupied by patients. A high-pressure boiler gives steam for sterilization, laundry, cooking, steam tables, the acceleration coils located in the vent hoods, and the vented drying-closet coils.

The sterilizing equipment is complete, and in each workroom there is a utensil sterilizer for bedpans and adjoining this is a warmed closet in which to place the pans after cleaning for the next call.

The signal system is a silent call type. The lighting fixtures are of a special type designed for patients' rooms to diffuse the light and avoid eyestrain. There are bedside light sockets for each bedside in addition. In the working portions of the hospital the lighting is direct and very adequate, so that the nurses can see and not have to feel what they are doing, avoiding in this a complaint which is frequently heard.

The many other features required to make the present-day hospital a successful working unit were all provided, when there was money for it, even to piping for a vacuum cleaner. The elevator is a modern push-button type.

The nurses' home is a plain, substantial two-and-one-half-story wooden building and accommodates with the superintendent's assistant, twenty people—the top floor is used at the present for female help.

The rooms are of the standard size 9 feet by 12 feet, and the usual assembly and other recreation rooms are under the same roof. It serves its purpose in a splendid way, and an interesting point is, that the cost, exclusive of furnishings was only $12,261. The hospital building cost



Fig. 10. The rooms of the third floor are extremely cool in summer and are much in demand.

$73,981, including laundry, kitchen, and sterilizer equipment, elevator, refrigerators, awnings, screens, window shades, and architects' fees.

The building operations were started in May, 1916, and the hospital was opened in July, 1917.

VARIOUS FORMS OF HOSPITAL INSURANCE

More Important Than It Is Generally Thought—It Is Well To Receive Expert Advice in Regard to Rates and Protection

By L. R. CURTIS, St. Luke's Hospital, Chicago

INSURANCE in its various forms is worthy of more consideration than it usually receives in hospital administration. In any discussion of this subject, we may assume as a foregone conclusion that it is wise, provided the cost is within reason, to purchase protection from all of the various risks which can not be eliminated.

Unless the person handling insurance matters is well versed in the matter of rates and forms, it would in nearly every case be profitable to have an expert make an analysis of the line with special regard to determining whether the rates are the lowest obtainable and if the degree of protection offered is adequate. Reduced rates may often be secured by making inexpensive changes.

The various forms of insurance applicable to hospitals may be listed as follows: fire insurance on buildings; fire insurance on contents; fire insurance on rents; general liability, covering personal damages to all persons not covered by the employees' compensation provisions; employees' compensation; elevator insurance; steam-boiler insurance; malpractice insurance, covering damage suits by patients; pay-roll insurance, covering theft of pay-roll money; burglary insurance, covering theft of money or valuable property belonging to the hospital or held in trust for patients; and fidelity bonds, covering losses due to employees. The foregoing list is not complete, but includes all the forms of insurance which are especially applicable to hospital risks.

Fire insurance on buildings and their contents is universal, but it is doubtful whether many institutions have increased their lines to meet the advanced cost of replacement under the present scale of prices. It is proper also that the property of resident officers, physicians, and nurses should be covered by the policies.

Insurance on rents is not so common, but in cases where income from rented property is used in the support of an institution, the same reason applies for covering income as for protecting the capital investment.

Employers' liability, general liability, elevator,

and steam-boiler insurance may be classed as indispensable. No institution can afford to carry these risks. In addition to protection from loss in damages, there is a distinct value in the inspections and advice relative to reducing accidents to a minimum. The loss from damage suits is not confined to damage paid, but lawyers' fees, court costs, and incidentals are a considerable item, even if the verdict is favorable. Many cases are abandoned when the claimants find they are opposed by an insurance company.

In regard to the malpractice risk, it may be said that every hospital, however well-conducted, is open to claims and suits for damages by patients. Some of these may have a more or less substantial basis for claims, others are trivial, but the greater proportion have no just cause for a claim. Often suits are instituted with the belief that the institution, having taken into account the uncertainty as to the verdict, the expense of litigation, and the resulting disagreeable publicity given to exaggerated statements by the claimant, will make some sort of a settlement. Insurance tends to reduce the number of suits. I have heard it argued that insurance of this kind would have a tendency to make the hospital attachés less careful and conscientious in their work, but I am satisfied that this is not true in hospitals of the better class.

Pay-roll insurance is relatively new. It covers funds from the time the money is taken from the bank until it is distributed, usually with the reservation that it shall be distributed the same day it is drawn. With the very numerous robberies during the past few years in the larger cities, the protection afforded is well worth while.

Burglary, or robber insurance, is desirable only if considerable amounts of money or valuables are kept on the premises. It is usually written to include money in transit to the bank.

Fidelity bonds are a very necessary form of precaution. Nearly all corporations require that all employees in positions of trust, or who handle or have access to money, be bonded. It does not reflect on the person bonded, and it not only secures the employer against loss, but I believe that it acts as a deterrent against temptation.

If the hospital owns and operates an ambulance, insurance of this class should be carried in addition to the others mentioned.

THE ANESTHETIST ON THE HOSPITAL STAFF

Specially Trained Anesthetists Save Life, Facilitate the Work of the Surgeon, and Help to Establish the Hospital's Reputation—Anesthesia a Branch of Medicine Too Long Overlooked

By ISABELLA C. HERB, M.D., Chief Anesthetist, Presbyterian Hospital; Instructor in Anesthetics, Rush Medical College, Chicago

IN the commercial world in every vocation and every line of industry in which there is danger to life, the state law compels safety devices or the posting of danger signals to warn employees. The fact cannot be gainsaid that a large proportion of the anesthetic deaths are preventable, and yet what are the precautions generally taken to safeguard the patient during narcosis? The saving of life in this respect demands the attention of the entire medical profession. The anesthetist who kills the patient through overdosage or the improper selection of the anesthetic can no longer hide behind "heart disease" or "the status lymphaticus," and, in common vernacular, "get away with it," at least not with those who are prone to analyze results or cause and effect.

The slogan to be adopted, the safety device, is a single word, "education." Every medical college should give theoretical and practical instruction in anesthetics, and this course should be made compulsory, before a student is admitted for graduation. Fortified with such instruction, the graduate who serves an internship in a well-regulated hospital with a qualified anesthetist on its staff will be a distinct asset to the community, regardless of the branch of medicine he may elect to practice. Nothing can improve the status of the qualified anesthetist more than the education of physicians generally, in the subject of anesthesia. Gatch says, "Any art must suffer if it lacks an intelligent and appreciative clientele. By the extent to which anesthesia as a specialty fails to command the support of the medical profession, is to be measured the failure of the latter to appreciate the advantages of good anesthesia."

The public is surely learning the gravity of anesthesia in both its immediate and remote effects, as is evidenced by the fact that patients frequently ask, "Who is going to give me the anesthetic?" or engage the anesthetist in the same manner as they engage the surgeon. When people generally understand that the life of the patient often rests with the anesthetist, better anesthetic service will be demanded, and the administration of anesthet-

tics will assume the importance and dignity it deserves. Fortunately the time is past when the most inefficient person present is chosen to administer the anesthetic. W. W. Keen, a surgeon of wide experience and international fame, has pertinently said, "Next to the surgeon and even before his first assistant stands the anesthetist holding the scales of life and death."

Combine experience with an observant, analytical mentality and a clear judgment, and the result is an efficient person whose opinion can be respected. The anesthetist who has these qualifications and who also possesses tact, sympathy, and a reassuring personality is a definite asset, not only to the surgical department, but to the hospital that claims him as a member of its staff. The influence that such an individual exerts is unconsciously felt throughout the institution. It is passed from physicians to nurses, from nurses to patients, and from patients to friends, and the result is that a confidence is established before the patient goes to the operation room. Naturally the fear of the anesthetic is thereby lessened if not altogether abolished.

THE RELATION OF THE ANESTHETIST TO THE SURGEON

Perfect confidence, understanding, and harmony should exist between the surgeon and anesthetist or else the best interests of the patient may be sacrificed. In all surgical risks it is a wise procedure for the surgeon and anesthetist to consider the case together. When the surgeon has explained the surgical procedures he desires to institute, the physical condition of the patient and operative requirements can be discussed and the selection of the anesthetic and the method of its administration determined. Of course this procedure can be followed only when qualified, experienced anesthetists are employed.

What are the advantages to the surgeon in working with the specialist in anesthesia? The surgeon who has confidence in the judgment and ability of the anesthetist is relieved of all anxiety and worry as to the condition of the patient and his mind is free to engage in the surgical problem at hand. He is aware that the anesthetist is ever on the lookout for changes in respiration and circulation and will warn him of impending danger or approaching shock. The capable anesthetist, knowing the exact condition of the patient, can guide the surgeon intelligently as to the advisability of added operative procedures. This so-called "team-work" is responsible for better surgery and safer anesthesia, both immediate and remote. Furthermore, the patient is made to feel that the surgeon has left nothing undone which will contribute to the success of the operation. It has been my experience that those surgeons who are most familiar with anesthetics, their action and the different methods of administration, are the ones who are most willing to consult with or be influenced by the qualified anesthetist. It is only just to assume that the physician who devotes all his time and study to this particular field of medicine should be better informed than the surgeon whose studies are along the line of surgery; consequently a qualified anesthetist is primarily a consultant.

THE RELATION OF THE ANESTHETIST TO THE INTERNS

The value of supervision of the anesthetics given by the inexperienced interns can not be overestimated. He learns the method of handling patients with tact and courtesy and of allaying their fears and apprehensions, thus obtaining their confidence and assurance in his ability. The instruction of interns should be directed toward the administration of anesthetics in such a manner that the occurrence of complications due directly to the anesthetic may be foreseen and prevented.

The beginner in the administration of anesthetics should be supervised in the same strict manner that he is in other branches of medicine and surgery. His college course does not fit him for anesthetic work any more than it fits him to perform operations or assume the care of a severely sick medical patient without supervision. The surgeon who relegates the administration of the anesthetic to the untrained junior intern without supervision is morally responsible for the outcome. It is just as reasonable to turn over to him the surgical patient and allow him to operate without guidance and expect him to do satisfactory work.

Interns enter hospitals in order that they may be taught to put properly in practice, under experienced supervision, what they have been taught theoretically in college. Just why surgeons should expect these men to be competent to administer anesthetics is as incomprehensible as that they are willing to risk the patient's life in their hands. Surgeons, in general, are too prone to let the administration of anesthetics be a matter of unthinking routine. Ignorance is not bliss when life is at stake. Danger must be recognized before it can be eliminated, and the proper instruction of interns is not possible without qualified anesthetists on the staff. The proper teaching of anesthetics makes the administrator thoughtful, attentive, and wary. It gives him confidence and wisdom under trying circum-

stances as well as a desire to seek more light the more he finds. The wish to acquire more knowledge and the finding of it brings joy in one's work and abolishes completely all thought of monotony or drudgery. The most successful teacher is he who can arouse the greatest amount of interest in the subject at hand. Flagg says, "The proper administration of an anesthetic is more than a mere mechanical performance; it is an art. To give an anesthetic is one thing, to practice the art of anesthesia is another." At the close of every intern's service he should be master of the principles of anesthesia and the different methods of producing and maintaining narcosis with a minimum of risk and a maximum of competence.

THE RELATION OF THE ANESTHETIST TO THE PATIENT

The relation that the anesthetist bears to the patient is analogous to that of the surgeon. The life or future well-being of the individual may be jeopardized through the carelessness or ignorance of the one or the other.

After the anesthetist is acquainted with the physical and mental condition of the patient and the operative requirements and preliminary preparation, the anesthetic to be given and the method of its administration can be determined. The attitude of the anesthetist toward the patient should be gentle and sympathetic. Mystery is disconcerting to most people; consequently it is the better part of discretion to inform them why certain details, such as the position on the operating table or covering the eyes, are necessary. One of the greatest assets an anesthetist can have is the ability to gain the confidence of his patients.

THE OBLIGATION OF THE ANESTHETIST TO THE HOSPITAL

The same confidence which exists between the surgeon and the anesthetist should exist between the hospital management and the anesthetist. It is the duty of the anesthetist to consider that it is a part of his work to help maintain a high standard reputation for the hospital and to promote its interests by avoiding undue waste. It is desirable that he administer the anesthetic to all patients whose general condition makes the administration especially hazardous, as a large majority of these patients can be safely carried through a properly conducted anesthesia.

Only established methods of anesthesia should be employed or allowed. All experimental work should be confined to the lower animals, and then sufficient time must be allowed to elapse for secondary effects to manifest themselves before the anesthetic or method is used in the hospital.

The report of the committee on anesthesia of the American Medical Association (1912) was to the effect that, "Every hospital, certainly every large hospital, should have as a regular member of its staff an attending anesthetist whose authority in his special branch should be as complete as that of the attending surgeons in theirs."

THE RELATION OF THE HOSPITAL TO THE ANESTHETIST

The hospital that has not a qualified anesthetist on its staff is a menace to the best interests of the prospective patient and attending surgeon. What is meant by a qualified anesthetist? The qualified anesthetist is one who is capable of making a physical examination of the patient, who can interpret laboratory findings, who is familiar with operative requirements and able to weigh the evidence and select the most suitable anesthetic and method for its administration for the particular patient under consideration. These qualifications require not only a medical education but special training in the theory and practice of anesthesia as complete as is demanded in the field of surgery or its correlated specialties. The tyro who gives an occasional anesthetic, or the medical man who gives a few anesthetics to help pay expenses, should not be considered qualified. It may be urged that I have made the requirements too high and I will reply by asking if less is demanded of the physician who specializes in other branches of medicine? And yet, with the exception of surgery, there is no part of medicine the practice of which is capable of destroying life so quickly as is the administration of anesthetics.

All matters pertaining to the department of anesthesia should be referred to the anesthetist in charge. He should be privileged to purchase, at the hospital's expense, such apparatus as is required for successful work. He should also be allowed the brand of anesthetic that according to his experience and investigation is the purest and consequently the safest.

I can not refrain from making a plea for the unfortunate poor in our county institutions. The hospital management should not allow these people to be used by a set of faddists to demonstrate some new agent or method of anesthesia or to revive a method which has been abandoned because of high mortality or evil secondary effects. The economic and social value of a charity patient may be greater than that of the private-room millionaire.

REMUNERATION

For years the professional anesthetist has been recognized in England, but it has only been recently that the United States has developed this

specialty, although the first anesthetics were given here and the greatest advancement in this science must be credited to American physicians.

In order that medical men and women shall devote their time and study to anesthesia, the public as well as the medical profession must be taught that safety lies in having the anesthetic well administered and that such expert service must be properly recompensed according to the skill required and the responsibility assumed. It is evident that the medical profession itself does not sufficiently appreciate this point.

Unless the anesthetist is a full-time teacher with a regular stipulated compensation his services should be paid for by the patient, as is the operation fee. This relieves the hospital of the responsibility and the extra expense of maintaining an anesthetist. This arrangement at once changes the whole complexion of the situation. The anesthetist assumes a personality which he did not before possess, for he has been only a part of the hospital machinery and looked upon by the surgeon and patient very much as the surgical nurse, orderly, or other operating-room appurtenances are. Patients are not only willing but glad to pay the extra fee if the occasion for it is properly explained to them. The fee to be charged must rest upon the financial circumstances of the patient and the difficulties of the anesthesia. The bills should be sent directly to the patient from the anesthetist and not through the surgeon or the hospital. This latter point is important to the anesthetist, as it establishes an acquaintance with the patient and his friends, and, if the anesthesia has been satisfactory, they will think of him for other operations.

A CHILDREN'S DISPENSARY ORGANIZED ON THE BASIS OF APPOINTMENTS FOR PATIENTS

History-Taking by Lay Assistants Proves Satisfactory—Substitute Procedure in Absence of Medical Assistants—Routine Investigation of Diets of First Importance in Efficient Work

By EDWARDS A. PARK, M.D., and Co-Workers, Johns Hopkins University, Baltimore*

INTRODUCTION

EARLY in 1918, M. Berryer, Minister of the Interior of the Belgian Government, working in conjunction with the Commission of the American Red Cross for Belgium, determined on the establishment in Le Havre of a medical organization which should care for the children and pregnant women of the twenty thousand or more Belgian refugees gathered there. He secured a theater, named "La Salle Franklin", after Benjamin Franklin, and assigned the organization of the obstetrical work to a Belgian staff. The task of organizing and conducting the relief work for the Belgian children he entrusted to the American Red Cross[1].

The peace-time population of Le Havre of one hundred and fifty thousand had been swollen by an influx of refugees and the families of working men and soldiers to an unknown figure, generally estimated at two hundred and twenty thousand. This surplus population, approximating seventy thousand, had been forced to find lodgings in a city already filled to its normal capacity, for not a single new building had been erected anywhere. The crowding in the poorer parts of the city was so extreme that whole familes lived in single rooms. The rents which the refugees and other newcomers were obliged to pay were more than three times their pre-war value. The prices of food, coal (which was rationed), clothes, and household supplies had at least tripled. The great majority of the doctors of Le Havre had been mobilized; the few who remained were for the most part occupied with clientèles able to pay. Diseases of various kinds were prevalent, chief among them tuberculosis; and a whole variety of minor ailments, the result of scarcity of food, unhygienic conditions, vermin, and neglect, were common. The suffering among the French refugees and the poorer classes of the fixed population of the city was even greater than among the Belgian refugees, whose interests were ably looked after by their government.

In the presence of the stimulus of such need for medical aid the new organization grew rapidly. A children's dispensary was created. The relief work was extended to the French. A barrack hospital was built. A training school for French and Belgian nurses' aids was established. The systematic visitation of all new-born infants and the supervision of their health for the period of one year was undertaken in the most crowded and oldest quarter of Le Havre, the St. François quar-

*Written in collaboration with Dr. Alma Rothholz, Dr. Ruth Guy, Dr. Rena Crawford, Miss Ethel Damon, Miss Mabel Wilcox, and Miss Ruth Washburn, of the Johns Hopkins University, Baltimore.

1. Mr. Ernest Bicknell was commissioner, Mr. John van Schaick deputy commissioner, and Dr. Mason Knox, Jr., medical advisor to the commission when the work in Le Havre was inaugurated. Dr. E. A. Park was medical director, and charged with the organization of the work.

ter. All conditions were propitious for the freest development. The staff[2] of the new organization had no extraneous duties. The Belgian Commission was liberal in its financial support and never attempted to interfere with the development of the new organization.

When the Commission of the American Red Cross for Belgium ceased its activities in Le Havre on March 10, 1919, the private charitable organizations of the city interested in infant welfare united under the leadership of Dr. Gibert and, joined by the prefecture and the municipal government, raised the necessary funds and made the organization a permanent institution.

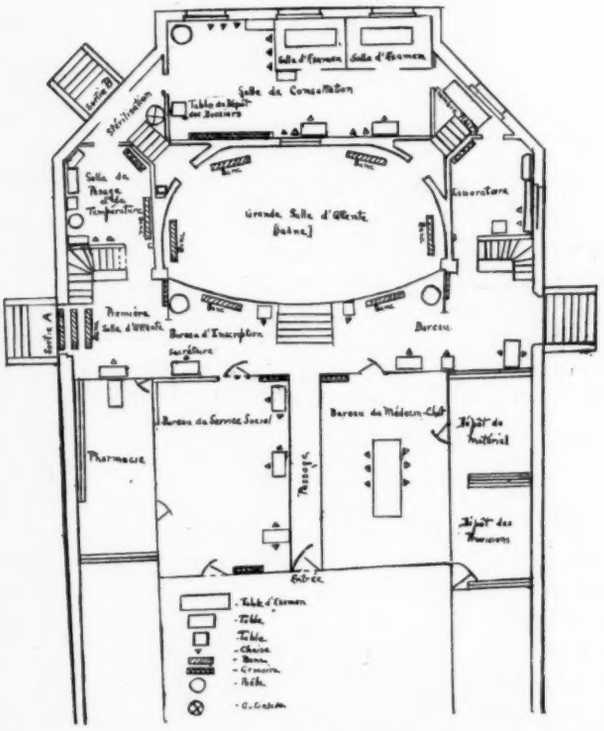


Fig. 1. Floor plan of stage and theater converted into dispensary.

Of the different branches of the organization the dispensary was the most important; it was the pivot around which the others turned. Its great success was due in large part to its organization and methods of administration, which differed in several respects from the conventional organization and methods of administration of dispensaries. The following pages, taken from the report submitted to the commission for Belgium in regard to the medical work conducted in Le Havre are limited to the discussion of the organization and methods employed in the dispensary. It is believed that certain dispensary methods used in America could be altered and that certain of the features which characterized the American Red Cross dispensary in Le Havre could be adopted to the advantage of the patients. In particular, it is thought that dispensaries can be operated on the appointment system without difficulty, and that lay assistants may be used successfully for case history-taking in children's clinics, and, finally, that there is no way in which a children's dispensary can be made to perform so useful a service to the community as by systematically investigating the diet in each case as a routine procedure, and advising in regard to it from both the medical and economic standpoints.

2. The Commission of the American Red Cross for Belgium obtained the greater part of its staff of doctors and nurses from the children's bureau of the American Red Cross in Paris.

THE ARRANGEMENT OF THE DISPENSARY

The dispensary occupied the northern end of the theater of La Salle Franklin, the stage, and surrounding dressing rooms. The use to which the allotted space was put is indicated in the accompanying floor plan (Fig. 1).

The patient entered the dispensary by *passage*, turned to the left to the clerk's table (*secrétaire*), or, if the clerk was occupied, waited on *banc* at left of stairs to stage. When the registration was completed, he proceeded to *première salle d'attente* (the first waiting room), and sat on one of the benches until called to enter the *salle de pesage et de température* (the weighing and temperature room). The chart was sent by the clerk to the weighing and temperature room, preceding him there. When it became the turn of the patient to have weight and temperature taken the nurses' aid summoned him from the first waiting room to the weighing and temperature room. The record of the temperature and weight was written in ink directly upon the chart on the left-hand side of the page by the nurses' aid taking them. From the weighing and temperature room the patient was sent via the *salle de stérilisation* (sterilization room) to one of the benches in the *grande salle d'attente* (main waiting room), where he waited until summoned into *salle de consultation* (consultation room). It will be observed that the benches in the main waiting room were placed four meters (about thirteen feet) apart in order to limit to the greatest extent possible the contact of children waiting there for examination. The chart of the patient was carried by one of the nurses' aids from the weighing and temperature room to the consultation room and placed upon the chart table (*dépôt des dossiers*) situated there. When the patient's turn for examination came, he was summoned from the main waiting room into the consultation room by one of the aids working under the doctor's direction in the consultation room. When the examination was finished, the patient made his exit through the sterilization room and the main waiting room to the desk of the clerk, who gave the appointment for the next visit, and saw

to it that any prescriptions calling for drugs or food, or any orders for assistance from the nursing or social service department, were referred to the proper persons. If the patient was a new case, the nurses' aid took the history at one of the tables situated on either side of the front stairway leading to the stage. There were two additional examining rooms situated in one of the galleries of the theater which are not indicated in the floor plan.

We point out merely that the arrangement of a series of small rooms (the dressing rooms) around a central waiting room (the stage) was excellent in principle, and that the shallow rooms with high double windows made the best kind of examining rooms. It will be seen that it was possible to establish a progression, i. e., so to arrange space as to enable the patients to move steadily from one point to another during their passage from the *bureau d'inscription* through the weight and temperature rooms to the consultation room, where the examination by the doctors took place, without the necessity of retracing their steps[3].

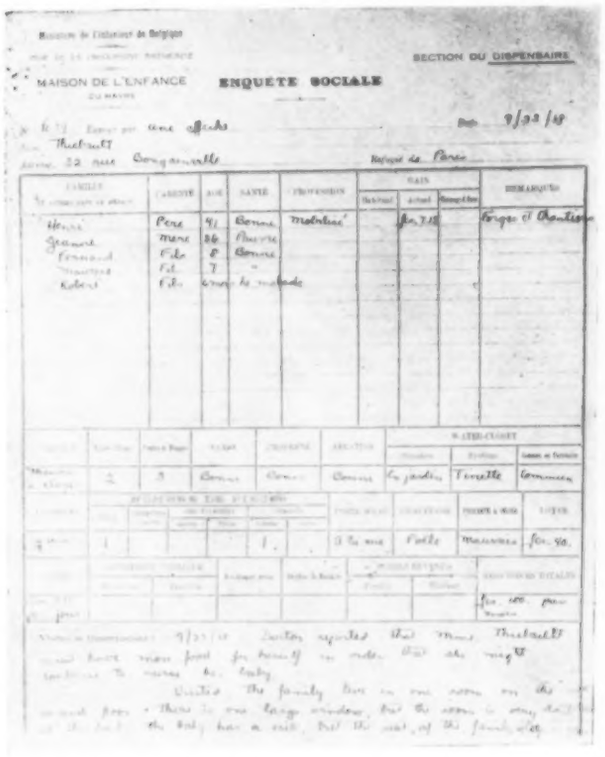
A FULL-TIME DISPENSARY

The dispensary with its staff in attendance was open for the examination and treatment of children from 9 a. m. to 5 p. m. each day with the exception of Saturday afternoon, Sunday, and the more important holidays. Inasmuch as the staff lived in the dispensary building, it was possible to keep the doors of the latter always open for the reception of emergency cases. The dispensary was thus a full-time dispensary. It rendered the special service of providing for the poor, who were denied recourse to private physicians, a place in which medical assistance could be had at all times and under all circumstances in case of need.

AN INTERCHANGEABLE FORM OF CHART FOR HOSPITAL AND DISPENSARY

A barrack hospital existed in connection with the dispensary. Accordingly, a form of chart was chosen which could be used interchangeably in hospital and dispensary. It was copied from the interchangeable chart used in the children's service of the Johns Hopkins Hospital, Baltimore. The complete chart consisted of a paper folder of standard typewriting size, insert sheets, sheets for social service reports, and sheets for the graphic records of temperature and weight.

The folder bore at the top of the first page a heading consisting of the name of the institution and of the Belgian Ministry under whose auspices the work was conducted, and immediately below this a printed form for the data universally required in the case of patients applying for hospital or dispensary aid: the name, age, date of first application, names and address of parents, dispensary number, etc. Except for the heading and printed form at the top of the folder just described, and a vertical black line forming a


MAISON DE L'ENFANCE ENQUÊTE SOCIALE

SECTION DU DISPENSAIRE

Fig. 2. Social service sheet showing form.

margin 3 cm. in width along the inner side of each page, both folder and insert sheet were blank. The object in having a folder was to provide something which would keep together the various single sheets above mentioned, and at the same time hold any correspondence or miscellaneous data pertaining to the case. The object of the insert sheet was to supplement the folder when the four pages of the latter had become completely filled. The sheet for the social service records (Fig. 2), colored yellow, was covered on one side by a printed form for social service data, but the reverse side was left blank for notes. Accompanying it were blank yellow sheets for the continuation of the social service observations. When a dispensary patient entered the hospital his dispensary chart was transferred at the same time, and the sheets for the graphic record of temperature and weight added. The usual special sheets for nurses' notes and for medication, and the results of laboratory analysis, were not provided for reasons of economy. The folder containing the various sheets described was always protected when placed in the file by

3. This statement is not strictly true, because at one point the stairway leading from the sterilization room to the main waiting room had to serve as both entrance and exit.

a stiff cardboard folder which bore the patient's number.

Although the chart used in our hospital and dispensary has been described in some detail, its exact nature is of little importance. The essential point is that the chart was such that it followed the patient from dispensary to hospital,

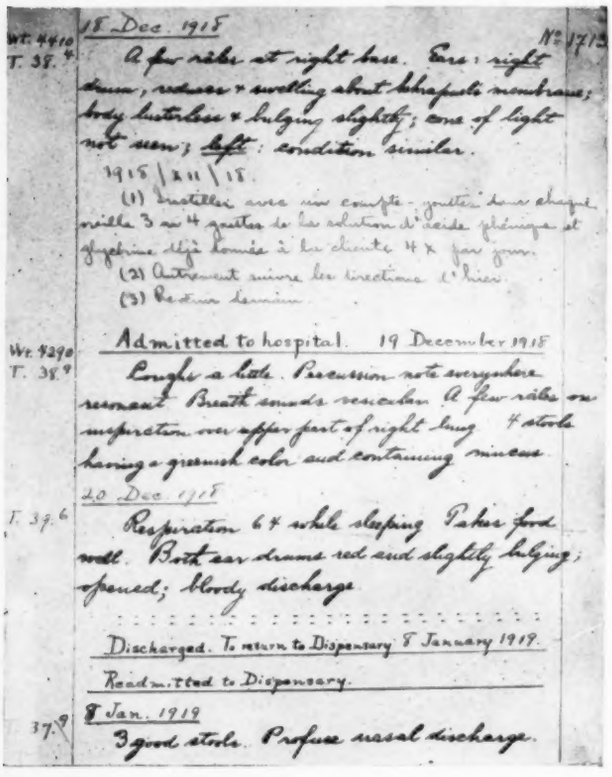

Wt. 44½0
T. 38.4
18 Dec. 1918
No. 1713
A few rales at right base. Ears: right drum, redness + swelling about lateral membrane; body distorted + bulging slightly; cone of light not seen; Left: condition similar.
1918 | XII | 18.
(1) Instiller avec un compte-gouttes dans chaque oreille 3 ou 4 gouttes de la solution d'acide phénique at 4% dans la journée à la chaleur 4 x par jour.
(2) Autrement suivre les directions d'hier.
(3) Rester ici.
Wt. 43½0
T. 38.9
Admitted to hospital. 19 December 1918
Cough a little. Percussion note everywhere resonant. Breath sounds vesicular. A few rales on inspiration over upper part of right lung. 4 stools having a greenish color and containing mucus.
20 Dec. 1918
T. 39.6
Respiration 64 while sleeping. Pulse fair and full. Both ears drums red and slightly bulging; opened; bloody discharge.
Discharged. To return to Dispensary 8 January 1919.
Readmitted to Dispensary.
37.9
8 Jan. 1919
3 good stools. Profuse nasal discharge.

Fig. 3. Page of chart showing use in both dispensary and hospital. The first item is the dispensary note; the second, carbon record of instructions to patients, with date of next appointment; the third, transference to hospital; the fourth, hospital note; the fifth, transference to dispensary; and the sixth, dispensary note.

and from hospital to dispensary, thus preserving a continuous and complete record of the case. There was no need to transfer the dispensary record to the hospital chart when a dispensary patient entered the hospital, or to transfer the hospital record to the dispensary chart when a patient discharged from the hospital was readmitted to the dispensary service. Thus the duplication of work always necessitated when hospital and dispensary have different forms of charts was avoided. (Fig. 3.)

THE APPOINTMENT SYSTEM APPLIED TO THE DISPENSARY

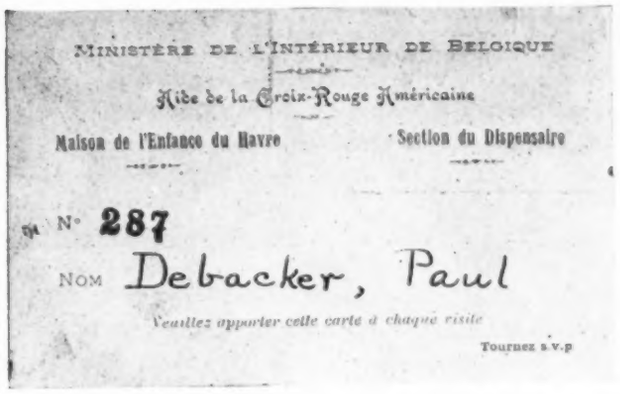
Children brought to the dispensary during its period of regular session were either seen by the doctor at once, or given definite appointments for the same day or for some subsequent day; in other words, patients applying for treatment were received exactly as they would have been by a busy private physician. The assignment of hours for the appointments was in charge of one person, the dispensary clerk, who kept the daily register and acted in the capacity of a secretary in the office practice of a private physician. Her desk was so placed that patients entering the dispensary naturally passed before it. On her desk lay the calendar containing the list of appointments for the day and for succeeding days.

The appointment system as employed in our dispensary was carried out in the following manner: A child applying to the admitting clerk for examination was given an appointment immediately if one of the ensuing periods on a doctor's schedule was free. If such a period was not free the action of the dispensary clerk was governed by the urgency of the case. If immediate examination was necessary because of the illness of the child, or the inability of the parent to wait or to return, or for some other reason, the child was registered immediately, and then sandwiched in between two cases having regular appointments. If the case was not urgent, the appointment lists were consulted to determine the free periods, and the parent allowed to select the one most convenient. A doctor was always at the disposal of the dispensary clerk to determine the urgency of the case from the medical standpoint.

After the consultation the date for reappointment was, of course, always made by the doctor, who alone was conversant with the patient's needs, and was communicated by him in writing to the clerk, at the bottom of the treatment slip (Fig. 3 second item). Only the date for reappointment, however, was arranged by the doctor. The hour was always determined by the dispensary clerk after consultation with the patient and examination of the appointment lists.

When the dispensary clerk had fixed upon the appointment hour most suitable to the patient, whether the patient was a new case or an old one, she entered it, with the date, on the reverse side of the dispensary card which the patient was to take away with him (Figs. 4 and 5), and then wrote the patient's name and number under the corresponding date on the appointment calendar (see table showing list of appointments for February 7, 1919).

Appointments were made to fall due on the hour and the half-hour. If the case was a new one a half-hour was regularly allotted to it, and ordinarily no other assignment was made for that half-hour on the doctor's schedule. If, however, the child had been seen previously, particularly if it was thought that little time would be required for examination and treatment (e. g., feeding cases returning frequently), other old cases were assigned to the same half-hour period.


MINISTÈRE DE L'INTÉRIEUR DE BELGIQUE

Aide de la Croix-Rouge Américaine

Maison de l'Enfance du Havre — Section du Dispensaire

N° 287

NOM Debacker, Paul

Veuillez apporter cette carte à chaque visite

Tournez s.v.p

Fig. 4. Front of dispensary card kept by the patient.

Ordinarily no appointments were made on the doctor's schedule between 11 a. m. and 1 p. m., or between 4 p. m. and 5 p. m., in order that there might be some time free for emergency cases. Thus it was possible to examine the great majority of new patients on the day of application.

LIST OF APPOINTMENTS FOR FEBRUARY 7, 1919.

RENDEZVOUS

le 7 Fevrier 1919.

A.M.

9:00 Saunier 148*; Van der Meutter 567; Gonidec 2081*; De Stryker 552*; Bloc 1589*; Barriaux 2026; Le Gay 98; Delavigne 2011*; Kooy 857; Cosse 187*.
9:30 Guyot 1396; Gouriou 183*; Fouquier 1981; Caluwé 189*.
10:00 Leen (new); Chapelain 1310 et 1311* (twins; Leprovost 785*, to be weighed before and after nursing.
10:30 Legris 1904; DeMaker 1657; Van der Kruyssen III.
11:00 De Groote 1834; Dubois 897; Osmont 1910, 1911, 1912.
11:30 Lachèvre 49; Fauger 752; Lafont 1046; Rose 33.

P. M.

2:00 Barray et Gontier (new); Guillaume 303; Hymans 803; Libert 571*.
2:30 Praet 253; Robience 998*; Brassine 55.
3:00 Besnard 523; Van Cassel 84; De Gras (new).
3:30 Fontaine 75; Labbeke 1207; Bremer 350*.
4:00 Vallé 1212; Morin 1273; Pitte 1194; James 1252.
4:30 Fourmanoit 263; Stuekkens 1127.

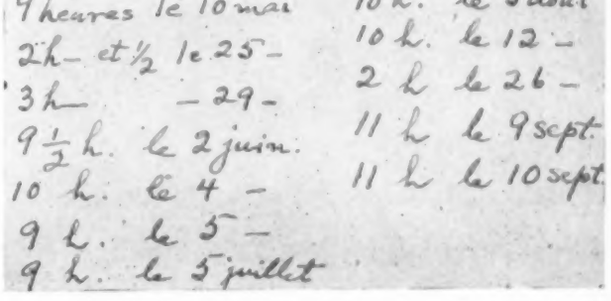
*Regulation nourishment.

THE ADVANTAGES OF THE APPOINTMENT SYSTEM

The advantages of the appointment system are so obvious as to require little comment. Perhaps the most important result from it in our dispensary was the saving of the parent's time and, therefore, of his money. The day's wage is of as much importance to the dispensary patient as the day's income to the dispensary doctor; its steady flow is often a matter of vital importance. Yet the dispensary system generally in use, according to which the patients are obliged to assemble before 9 a. m. or 2 p. m., and then to wait often the whole morning or afternoon, implies that the time of the dispensary patient is of so little value that it may be almost disregarded. The truth is that the modern dispensary is conducted, primarily, with a view to the convenience of the dispensary physician, on the principle that it is better for forty patients seated on the benches to lose sixty hours' time, than for the doctors to be subjected to the possibility of losing one-half hour's time. As everyone who has worked in children's dispensaries knows, many a parent who finds himself obliged to sacrifice his day's wage, or, if he works at night, his day's sleep, will not bring his child to the dispensary. Yet such a parent will bring his child to meet the doctor on a day and hour found to be mutually convenient.

In fact, as applied to the dispensary, the appointment system not only causes no loss of time to the doctor, but brings about the very best utilization of his time by producing a more even distribution of patients throughout the dispensary day and week. The avalanches of patients which descend on Mondays, on the days following holidays, or the first pleasant day after a period of bad weather, can, to a great extent, be anticipated, or held and distributed. The doctor thus avoids the frequent necessity of abandoning all careful consideration of his cases in an effort to get rid of them as rapidly as possible. Furthermore, the assembling of crowds of children is obviated, exposure to contagious diseases minimized, and noise and confusion, the two attributes of children's dispensaries, greatly reduced.

From what has been said, it must not be thought that the appointment system always worked perfectly in our dispensary and at once freed us from all the ills of the old system. Waiting and crowding occurred, but, relatively speaking, to a limited extent. Sometimes, when groups of patients collected, the fault was with the patients who had come late; almost always, however, it lay with the doctors who were late themselves, or fell behind their schedule as a result of some emergency or for other reasons. When the system worked perfectly there were not more than six patients in the waiting room at any one time during the day. On several occasions visitors have remarked, "You have closed?" when, in reality, more than fifty patients were being seen in the course of the day.


Veuillez vous rendre au dispensaire à l'heure indiquée :

9 heures le 10 mai
2h- et ½ le 25-
3h- -29-
9½ h. le 2 juin.
10 h. le 4 -
9 h. le 5 -
9 h. le 5 juillet
10 h. le 5 août
10 h. le 12 -
2 h le 26 -
11 h le 9 sept.
11 h le 10 sept.

Fig. 5. Back of dispensary card kept by the patient, showing date and hour of appointment.

If the dispensary patient paid a fee to the dispensary doctor, as the private patient pays a fee to his physician, in other words, if the dispensary

doctor had been compelled by his own selfish interests to recognize the convenience and economic necessities of his patients, all dispensaries would have been operated on the appointment plan long ago. There is no reason that a dispensary created for the benefit of the poor should not be conducted from every point of view to their advantage.

CASE HISTORY-TAKING INTRUSTED TO LAY ASSISTANTS

With the growth of the dispensary and the development of medical work of other kinds in Le Havre, it became impossible for the doctors to continue to take detailed case histories of the patients coming to the dispensary. The work was, therefore, turned over to entirely untrained assistants, young Belgian and French women who were taking a three months' course of study to become nurses' aids. A plan for history-taking (in next installment of this article) was compiled, which contained illustrative questions and examples designed to show the form of statement and arrangement in which the facts should be recorded, with some additional special advice in regard to the elicitation of the facts in so-called "feeding cases." It was made as simple as possible and was limited to those subjects which it was thought a lay assistant was capable of investigating. The aids were required to study it until they were able to ask its questions from memory and were instructed when they recorded the facts to arrange them under the general headings of the history plan, and to adhere to the form of statement and the sequence observed in the illustrative examples.

If carefully prepared case histories of a children's clinic are examined, it will be found that a considerable proportion of each is composed of information which an intelligent lay assistant would have been able to ascertain if she had been properly directed. As a matter of fact, a surprisingly large part of the case history of a child is composed of the most ordinary statistics essentially of a non-medical nature which a lay helper can determine almost, if not quite, as well as a physician. Such, for example, are the ages of the parents, their occupation, the births of living and stillborn children, and miscarriages, enumerated in the order of occurrence, the weight of the child at different periods, the age at which sitting alone, standing, walking, talking, the eruption of the teeth, and the like occurred, and, in addition, the various feedings and régimes from birth to the date of presentation at the dispensary. Another considerable portion of the case history within the power of the lay assistant to investigate is concerned with the occurrence, or non-occurrence, of certain symptom groups indicative of well-known diseases or pathological conditions which it is customary to attempt to exclude as a matter of routine. Such, for example, are the chronic cough, hemoptysis, night sweats, fever, loss of appetite, flesh, and strength, suggestive of tuberculosis; breathing with the mouth open, snoring, attacks of otitis media, suggestive of adenoids; cyanosis, difficulty in respiration, convulsions, inability to nurse during the first few days or weeks after birth, suggestive of brain defect, injury, or hemorrhage, and certain other conditions; snuffles, blood-stained nasal discharge, peeling of palms and soles, eruption during the first two months, suggestive of congenital syphilis. Another portion of the case history which the lay assistant may be able to investigate with success relates to the past illnesses of the patient. The lay assistant cannot, to be sure, make discriminating judgments in regard to past illnesses —for example, that the disease which the mother called measles was in reality scarlet fever; she can furnish, however, the list of the past illnesses, with dates, which the mother thinks the child has had. There are, of course, certain parts of the case history which a lay assistant can not hope to investigate successfully; for example, past illnesses of indefinite character, or the present illness, which may be any one of a great number of diseases with most diverse symptomatologies, such as no history form could possibly anticipate. So long as the lay assistant is dependent on a form, she is naturally confined by the limitations of the form, and, therefore, to the investigation of those portions of the history which may be termed "fixed." In the case of children, however, the fixed portions frequently compose 80 or 90 per cent of the total. Particularly in the case of babies brought to dispensaries on account of indigestion, or for regulation of the diet (and they represent a large proportion of the cases in children's dispensaries), the untrained assistant can often obtain all the information which it is necessary to know. In general, the younger the patient the simpler the history, and the greater the proportion which the untrained assistant can elicit.

The histories taken by the nurses' aids with the aid of the history plan used in our dispensary were remarkably serviceable. They always supplied the doctor with the statistical foundation of the history; in a considerable proportion of cases they furnished him with all the essential facts. When they were incomplete he was usually able to complete them with a few well-directed questions. The interpretation of the information contained in them may not always have been correct —the peeling of the palms and soles, reported under symptoms suggestive of congenital syphilis,

for instance, may have been only a part of a physiological desquamation—there may have been important omissions. The suggestion, however, was there, and the doctor at liberty to investigate further if he considered it necessary.

As compared with the case histories taken by doctors themselves, or by medical students, the case histories taken by nurses' aids had certain superiorities. They possessed an absolutely uniform tabulated arrangement which made immediate reference to any portion always possible and which permitted a comprehension of the subject-matter without the necessity of reading every word. They were free from the irrelevant matter and misleading subjective interpretation so often found in case histories of medical students. They provided detailed information on certain important subjects, notably the diet, frequently omitted altogether. There was agreement among the doctors of our staff that for *practical purposes* the histories of the aids taken with the aid of the history plan were superior to the case histories taken by medical students allowed to follow their own judgment. The untrained assistant compensated for her lack of specialized knowledge by fidelity to a prescribed routine.

Naturally, when regarded from the standpoint of scientifically accurate records of disease, the case histories taken by the aids were miserable failures, the more inadequate the further the case was removed from the ordinary. We do not recommend history-taking by lay assistants as a means of obtaining case records to be used for scientific purposes, but as a substitute procedure when sufficient trained assistance is unavailable. Our experience demonstrates that for case history-taking in children's clinics skilled labor can be successfully replaced in large part by unskilled labor.

In the foregoing paragraphs we have discussed only what beginners were able to do. After one of the nurses' aids had taken twenty histories she was transferred to another field. We have not had sufficient experience to enable us to say what degree of proficiency might be attained by a lay assistant who took medical histories over a long period of time. We venture the opinion, however, that an intelligent person without medical education or experience could acquire enough of both in a comparatively short time to ensure complete and perfectly satisfactory histories even in difficult cases. We believe that the most satisfactory arrangement in a children's dispensary not designed to be a place of instruction for students would be to place history-taking in the hands of lay assistants employed solely for that purpose.

METHOD OF RECORDING DIRECTIONS GIVEN TO THE PATIENT

As in other dispensaries, children making their first visit were undressed and completely examined. After the first visit the examinations were complete or partial as the conditions seemed to demand. The method of recording the physical examinations in the charts was the usual one. The method of recording the directions given to the patient in regard to treatment, however, was not usual, and, though exceedingly simple, has not been used elsewhere, so far as we are aware.

At the very beginning of our work at La Salle Franklin it was determined to give all the direc-

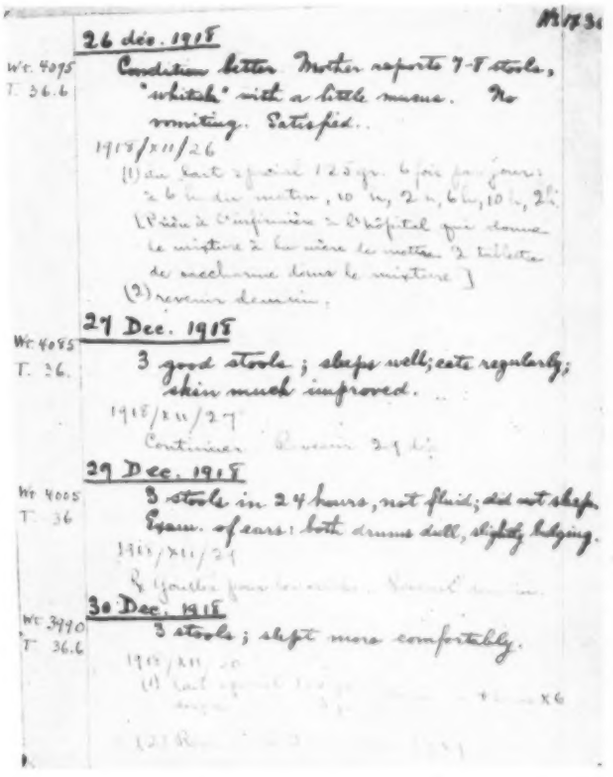

26 déc. 1918
Wt. 4095 T. 36.6
Condition better. Mother reports 7-8 stools, "whitish" with a little mucus. No vomiting. Satisfied.
1918/XII/26
27 Dec. 1918
Wt. 4085 T. 36.
3 good stools; sleeps well; eats regularly; skin much improved.
1918/XII/27
29 Dec. 1918
Wt. 4005 T. 36
3 stools in 24 hours, not fluid; did not sleep. Exam. of ears: both drums dull, slightly bulging.
30 Dec. 1918
Wt. 3990 T. 36.6
3 stools; slept more comfortably.

Fig. 6. Page of chart showing method of recording directions given to patients.

tions to the patient in writing, to make them detailed, and to retain exact copies in the chart. After trial of several different methods we adopted the following procedure: A sheet of carbon paper was placed face downward over that part of the chart on which it was desired to make the entry. A sheet of blank paper was then laid over the carbon paper. The directions were written in pencil on the sheet of blank paper, and were at the same moment transferred to the chart through the intermediary of the carbon paper. The directions written on the sheet of blank paper were handed to the patient; the carbon copy remained in the chart (Fig. 6).

It is scarcely necessary to comment on the

great advantage which accrues to the doctor in the treatment of a case if his directions have been given not only in detail but also in writing. In subsequent consultations he is then able to have before him an exact copy of them.

"How often have you given the baby his feedings?"

"Every three hours."

"But you were directed to feed him every four hours. There on the chart you can see for yourself."

Many dispensary doctors are willing to write directions for the patient in detail. Few, however, have the patience or time to make two copies, one for the patient, the other for the chart.

Another great advantage of the method of recording directions on the chart by means of carbon paper proved to be the ease with which it was possible to distinguish the directions in regard to treatment from the various notes in regard to symptoms and physical signs. The latter were always in ink, the former in carbon imprint. The differentiation was as sharp as if the notes had been made in blue, the directions in red (Fig. 6).

THE RECALL SYSTEM FOR PATIENTS FAILING TO KEEP APPOINTMENTS

Each morning between eight and nine o'clock the dispensary clerk took from the file the charts of all those children who had appointments for the day, and placed them in a pile in a basket on the admitting desk in the same order as that in which the children were scheduled to arrive. As each patient presented himself, the dispensary clerk removed the corresponding chart from the basket and sent it into the room where the weight and temperature were recorded on the chart; from there the chart was carried into the examining room; and after the examination it remained on the doctor's desk until the close of the dispensary session, when it was collected, together with the charts of the other children who had been seen by the doctors, and returned to its place in the dispensary file. The charts which remained in the basket on the dispensary clerk's desk at the close of the day were, therefore, the charts of those patients who had had appointments but had failed to keep them. This group of left-over charts the dispensary clerk gave to the doctor in charge of the dispensary. The doctor looked them through, selected the charts of those patients whose return to the dispensary was a matter of importance, and indicated to the dispensary clerk the means best adapted to bring about the return in each case. If it was very important that the child return to the dispensary, especially if the case was difficult from the social standpoint, the doctor asked that a social service visitor be sent. Under ordinary circumstances, however, he instructed the dispensary clerk to request the child's return, by postcard.

[To be continued.]

CONSTRUCTION OF ISOLATION HOSPITALS*

Choice of Superintendent First Requisite—Points to Consider in Deciding on Site—Contagion not Air-Borne—Desirability of Separation Room for Patients on First Entrance—Various Methods of Segregating

By D. L. RICHARDSON, M.D., Superintendent, Providence City Hospital, Providence, R. I.

PRELIMINARY to the building of a hospital for infectious diseases there are three important decisions to be made. The first is the selection of the superintendent. He should be a man who has had experience in a hospital for infectious diseases and one who has had some executive experience. Such a man should have had, also, general hospital experience, because there are many medical and surgical conditions that arise in, or are admitted to, a hospital for infectious diseases which require a well-grounded experience to meet them. The advantage of selecting the superintendent early is to put the burden of looking into the hospital construction and management elsewhere, and be available to watch the construction, make provision for the hospital equipment and organize the personnel at the proper time. This is very important. In small hospitals if a medical superintendent can not be afforded a nurse with general and infectious disease training should be selected early enough to see to the equipment and personnel.

The second is the situation of the hospital. Any hospital should be as centrally located as possible—particularly in large cities—and near car lines which furnish good service. However, central location should not be adhered to unless sufficient land can be obtained to furnish ample space about the hospital. It should be in attractive surroundings and have room for expanding. It is far better to go to the outskirts of a city to

*This is the fourth article in a series on the care of infectious diseases in hospitals. "The Care of Infectious Diseases in Hospitals," appeared in the April issue of The Modern Hospital, "Medical Asepsis in French and English Hospitals" in May; "Aseptic Nursing in American Hospitals" in July.

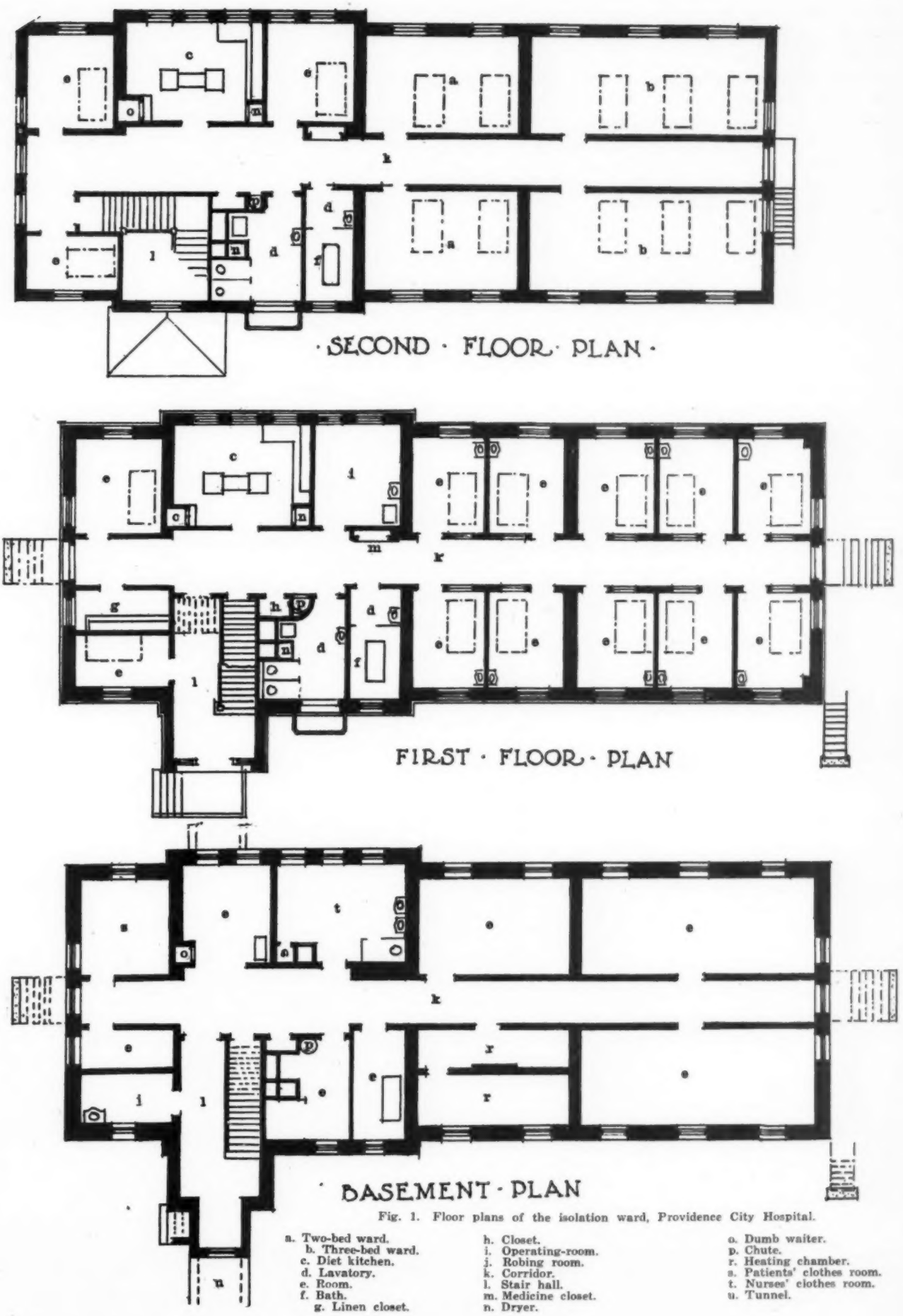


Fig. 1. Floor plans of the isolation ward, Providence City Hospital.

a. Two-bed ward.
b. Three-bed ward.
c. Diet kitchen.
d. Lavatory.
e. Room.
f. Bath.
g. Linen closet.
h. Closet.
i. Operating-room.
j. Robing room.
k. Corridor.
l. Stair hall.
m. Medicine closet.
n. Dryer.
o. Dumb waiter.
p. Chute.
r. Heating chamber.
s. Patients' clothes room.
t. Nurses' clothes room.
u. Tunnel.

obtain such a situation if necessary, for motor vehicles and trolleys make it entirely feasible. It should not be located near a busy railroad or noisy, ill-smelling factories. In very large cities, of course, it may be impossible to use such a location because of the distances involved. In such cases, valuable land will be required and many-storied buildings are to be preferred for economy. The upper floors where ventilation is the best can be reserved for patients. Complete fireproof construction is imperative.

There is no danger to any community from having a contagious disease hospital in its midst. Bacteria are certainly not wafted on the breezes to the neighborhood. In many studies, both in this country and abroad, no higher incidence of infectious diseases is shown among those living near such a hospital than among people living at a distance—assuming, of course, that patients are kept strictly to the hospital premises, by an enclosure preferably, in very congested districts.

There is no reason why contagious wards should not be attached to a general hospital. The chief advantages of such an arrangement are economy and better service to the patients. Such wards may receive the benefit of the hospital administration staff, kitchens, laundry, laboratory, and other utilities. It is not economical to maintain a separate contagious hospital of less than fifty beds and furnish strictly scientific and economic service. However, some general hospitals will refuse to consider such a proposition and a smaller infectious disease hospital can of course be operated and furnish very good service. Whenever infectious wards are established in connection with general hospitals the infectious wards should be in charge of a man who meets the requirements above referred to, although he need not have had so much executive experience. This is necessary to obtain best results, for many superintendents of general hospitals do not have the time, nor have they had the training, to conduct wards for infectious diseases.

The objects of a contagious hospital are to furnish good medical service and to remove the patient from the community lest he become a source of contagion. This can best be obtained by building and maintaining a modern hospital, well equipped, with a high-grade staff of physicians and nurses, and putting that hospital where it is easily accessible to relatives and friends of the patients.

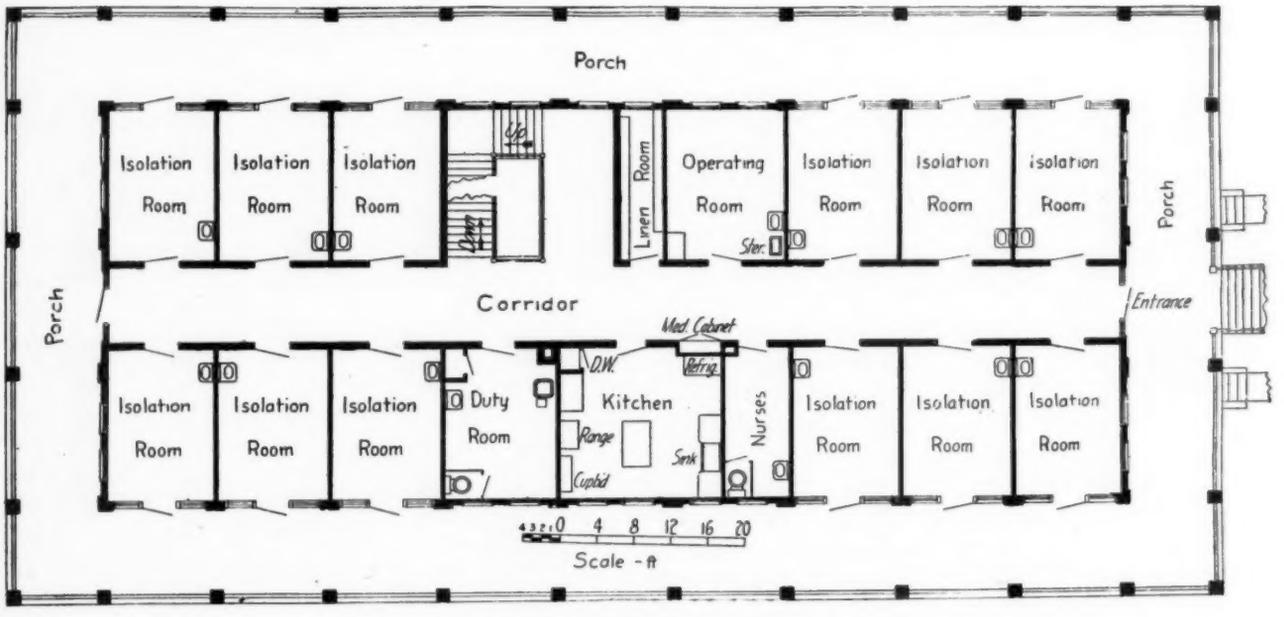


Fig. 2. Floor plan of the University of Michigan contagious ward.

A third question to be decided is what diseases shall be accepted for treatment. Heretofore, American contagious hospitals have limited their admissions to scarlet fever and diphtheria, sometimes including measles. Within a few years, there has been a broadening of their scope to include other common infectious diseases. This is especially true of such hospitals, mostly small, which have adopted aseptic nursing.

A modern infectious disease hospital should be able and ready to admit any kind of acute transmissible disease. It will be readily admitted that such hospitals are destined to be great teaching and investigation centers. They should attract many of the best medical men. During the last nine years, the following diseases have been admitted to the Providence City Hospital: cerebrospinal meningitis, chicken-pox, diphtheria, ery-

sipelas, gonorrhea (all forms), influenza, measles, mumps, noma, pneumonia, acute poliomyelitis, scarlet fever, septic sore throat and tonsilitis, syphilis, smallpox, trachoma, tuberculosis, typhoid fever, typhus fever, whooping cough, and many miscellaneous diseases and cases for observation. It will also be noted that money spent in the treatment and prevention of such diseases is the best kind of an investment.

Those contemplating building should first decide the scope of their work. If other existing hospitals care for some of these diseases it would be inadvisable to duplicate their work.

Having decided on the diseases to be admitted, it is important to study next the prevalence of these diseases in the community from the reports of the health officer and the registrar's figures. It will not be necessary to furnish beds for all cases of infectious diseases, for many people will not go to the hospital themselves nor send their children there for treatment. There are available figures to guide in the case of scarlet fever and diphtheria and from these an estimate may be made of the probable space needed for other diseases. In many English cities, about 90 per cent of scarlet fever and diphtheria patients are hospitalized. The rate is not so high in this country, anywhere from 25 to 75 per cent; 50 per cent being a fair average. However, the public increasingly tends to go to such hospitals when these are well built and well conducted.

It is not hoped, nor is it expected, that a hospital should accommodate all patients in a widespread epidemic, as in the case of measles and influenza outbreaks. It would be too expensive and would have little effect on the course of such an epidemic which was out-of-hand. Under such circumstances, the hospital should concentrate its attention upon the treatment of the sicker and more destitute patients.

If an infectious hospital proposes to accept all kinds of infectious diseases, at least one bed to every thousand or fifteen hundred inhabitants should be provided. One will be guided somewhat by the proportion of people living in tenements and apartments, who are more likely to go to a hospital.

In dealing with actual construction, it will be best to study the wards first. Such ward construction will apply equally to a complete isolation hospital or infectious wards in connection with general hospitals. Later will follow a study of general construction and the relation of infectious wards to a general hospital.

It should be a well-recognized principle not to build large open wards for contagious diseases. This has been a common mistake. There are two reasons. Hospitals with large wards are not usually provided with separation rooms for observing cases when first admitted, and they are often sent directly to these open wards with the



Fig. 3. Contagious ward at the University of Michigan.

convalescents. Since an accurate diagnosis is not always possible, this is a very dangerous procedure and often leads to institutional outbreaks.

A second reason is that, in case a child is admitted with a mistaken diagnosis or is in the incubation period of another disease, if, at the time, he is in a large ward and in contact with many other patients, he develops a second disease, many of his fellow patients are likely to contract it. If the open ward is small, not to exceed six patients, then the amount of damage done is small and will not hinder admission to other rooms in the same ward. By the term "ward," I mean all the rooms on a single floor and under one nursing unit whether it includes a large open ward or not.

As a general rule, at least 33 per cent, and better 50 per cent, of rooms for patients should accommodate not more than one or two patients, and no rooms more than half a dozen. The exception to this rule is when open wards are to be divided into cubicles or the beds well spaced for the bed-isolation method.

In general a good division of a ward for a sin-



Fig. 4. Exterior view of the isolation building, St. Luke's Hospital, Jacksonville, Fla.

gle disease, say diphtheria, is to have 25 to 30 per cent of the rooms arranged for a single patient, as many more for three patients, and the remainder of the rooms for not exceeding six patients. In isolation wards, where a great admixture of

diseases are to be admitted, rooms for a single patient, or at most two, should be the rule.

It will be appreciated that division into such small units makes it possible to use all wards if necessary for isolation wards. As the season's work quiets down, it is possible to transfer patients from one ward to another, thus not keeping several open wards for a very few patients.

The whole object is to provide accommodation for a variety of contagious diseases, for observation of all new cases of the more common diseases like scarlet fever and diphtheria, and to prevent the spread of secondary disease, should it be once introduced.

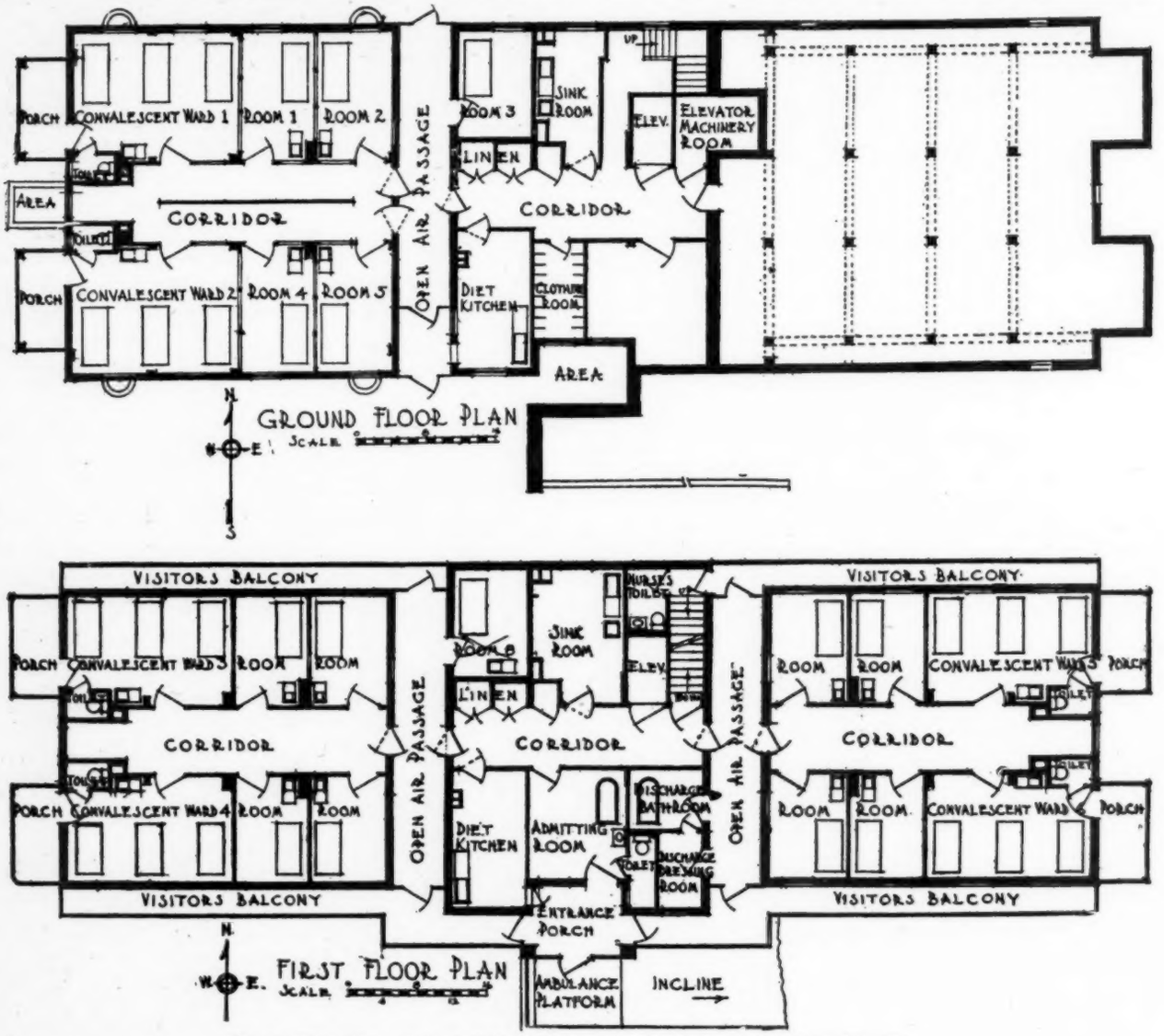


Fig. 5. Floor plans of the isolation building, St. Luke's Hospital, Jacksonville, Fla.

There are several methods, already referred to, of segregating patients into different units: the bed isolation system, the cubicle system, and the box or room systems. The first has its uses particularly in hospitals already constructed with large open wards. If the beds are ten to twelve feet apart on centers, lavatories placed at each end of the ward, hooks and shelf for each patient, it is very useful for infants and children who will not get out of bed, who are not suffering from early measles, chicken-pox or smallpox. The objection is that large children will get out of bed, particularly at night after the lights are out, and the aseptic technique is thus rendered useless. It is not through the fear of aerial transmission that large open wards are not advised, but because of the difficulty in controlling the patients. This can to some degree be remedied by putting the nurse's desk in a room next to the ward, leaving a broad opening into the ward so that the patients can be observed at all times.

The cubicle system, with incomplete partitions, is entirely satisfactory except that convalescent children may throw things over the top of the partitions. As a matter of fact, in original construction the saving in cost of such low partitions

over complete lath-and-plaster walls is very slight, if any, and the subsequent care of such partial partitions will certainly be more expensive. The cubicle system is most useful in subdividing large open wards just as has been done in England. Personally, I would advise complete walls separating the different rooms, for easier control of patients and for reasons of privacy. Walls of lath and plaster or plaster block and plaster are preferable.

When the ward is properly arranged it is preferable that the partitions between adjacent rooms should be complete. Under certain conditions a window may be put in this partition to allow the patient to see his neighbor. The rooms should be along both sides of a central corridor; doors should be opposite to each other to aid ventilation, and beside the door there should be a window to allow the patient to see his neighbor across the hall and to provide for further ventilation. In case of opposite or adjoining rooms containing patients of different sexes a sash curtain may be placed over the lower sash.

A room for one patient should be at least eight by twelve feet and better nine by twelve feet. One for two patients at least twelve by twelve feet. To provide elasticity, the rooms should be able to accommodate either a crib or a bed. The actual size will depend upon the position of the door, windows, and lavatory; bearing in mind the necessity of making it possible for the nurse to work between and around the bed without allowing her clothing to touch another bed or other furniture in the room. If there is working space enough there will be plenty of air space for the patient. Roughly, each bed should have floor space of 90 square feet. This generous working area also removes the patients far enough apart to diminish possible contact in case there are two patients in the same room.

Each room should be provided with a lavatory. In case the room is a large one it may be wise to have more than one, so that a nurse will not have to travel more than 25 or 30 feet to wash her hands. This is an important matter. It is useless to attempt aseptic nursing without enough lavatories to make handwashing as little trouble as possible. The hands must be washed in running water and the bowl should never be provided with a plug. The water should be mixed hot and cold, escaping from a single nozzle and the hands washed in as warm water as possible. It should be turned on either by a rugged foot lever, a knee lever, or an elbow lever, preferably the first. The objection to the forearm style is the danger of contaminating the lever with a gown-sleeve, and that the lever of somes types is long enough so



Fig. 6. Part of a box-room in the North-Eastern Hospital, London.

that packings do not stand up long. There are on the market, however, some very good forearm lever faucets. The objection to the knee lever is that it may produce a traumatic arthritis. A good foot-lever valve is probably the best, although the initial cost may be more than for the forearm faucet.

A towel rail 16 to 18 inches wide above the bowl provides a very convenient place to hang the individual hand towels.

There should also be a small shelf on the wall on which can be placed poisonous solutions, etc., and the patient's thermometer, high enough to be out of reach of a convalescent child. There also should be two hooks on the wall, conveniently placed but not too near the patient's bed, on which gowns can be hung, one for the doctor and one for the nurse.

The lights should be arranged to turn on by a switch in the corridor so that the nurse can light a room without contaminating her hands.



Fig. 7. Bed isolation, septic scarlet fever ward, North-Eastern Hospital, London.



Fig. 8. Administration building and series of wards, Philadelphia Hospital for Contagious Diseases.

There are two objections to too much glass in the room walls—lack of privacy, and the large amount of work required to keep it clean. The advantage is the better observation of the patients by the nurse. The plastered wall should be painted with a durable enamel paint so that the wall can be washed frequently if necessary. It has been found at the Providence City Hospital and elsewhere that soap and water is entirely sufficient for the cleaning process. In the first place, few disease organisms are to be found on the walls. Fumigation has been largely abandoned. A careful study of this matter will be found in the October, 1913, issue of THE MODERN HOSPITAL. Should one believe that disinfectants are necessary, it will be necessary to put up the wall for some distance of marble or some vitrified material. The floors need be constructed no differently than in any general hospital. Wood and linoleum are good, the latter being preferable. Terazzo, cement, or tile floors are excellent from the standpoint of cleanliness but are rather cold for the patient and hard on the nurses' feet. The horizontal angles at the floor and perhaps the vertical angles should be coved, to allow easy cleaning.

The general arrangement of the patient rooms and the utility rooms should follow those of any well-built general hospital. Utility rooms should be centrally placed to save steps.

There should be a toilet room with sufficient toilets for the use of convalescent patients from the same unit. An adult, who usually can be depended upon, may go to a common toilet room, but to a compartment marked with his name or disease. Hospitals are sometimes built with individual toilets and lavatories. This is unnecessary and entails a large initial outlay, takes space, and requires much work to keep clean. Seventy-five per cent of patients in contagious hospitals are children under ten or twelve years of age and they can easily use the bedpan either in the bed or on the floor, while convalescent adults can put this pan in a chair. When building for private patients, separate toilet facilities may be justified.

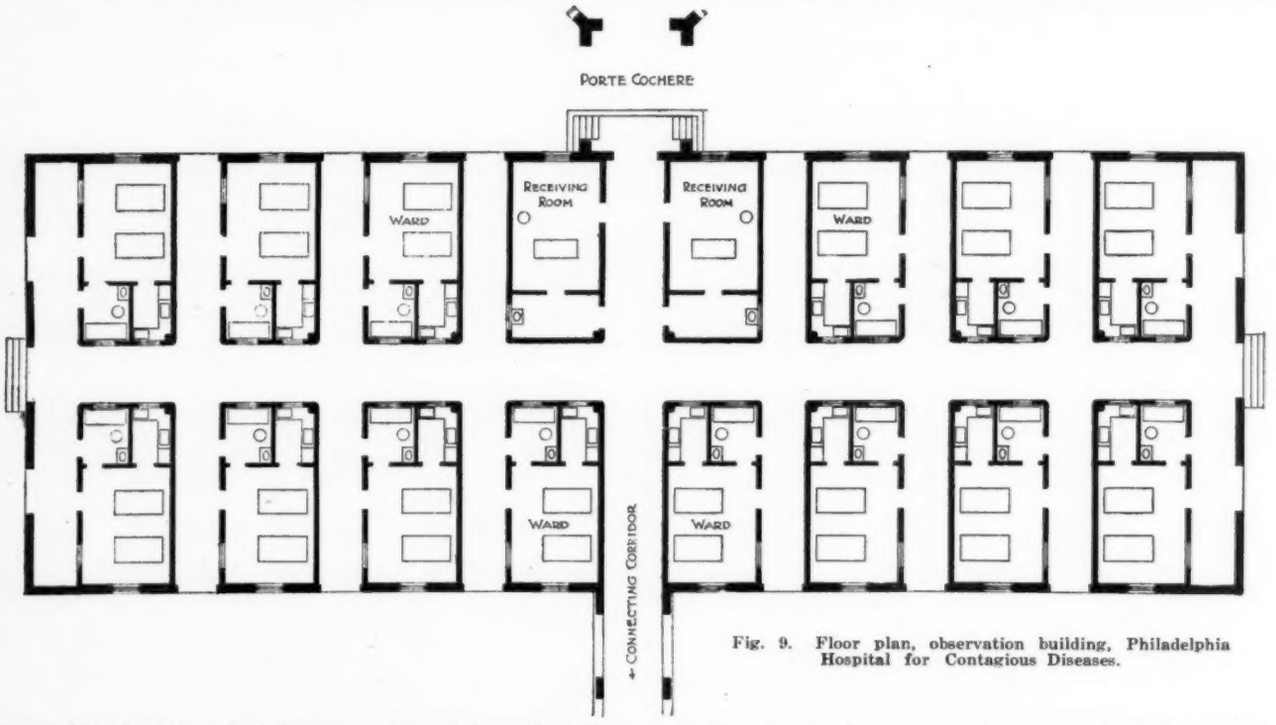


Fig. 9. Floor plan, observation building, Philadelphia Hospital for Contagious Diseases.



Fig. 10. Exterior view of the observation building, Philadelphia Hospital for Contagious Diseases.

In the toilet room or in a utility room should be installed a utensil sterilizer to sterilize bedpans and urinals. The ward kitchen should also be provided with a utensil sterilizer where all soiled dishes may be sterilized before washing.

The ideal way to dispose of linen is to drop it into a chute, through a door with a spring hinge and a hook, so that it can be opened by the fore arm. This linen should drop into a canvas bag in the basement, in which it is collected to be sent to the laundry. Otherwise it may be kept in the corridor or utility room, and regularly collected. The bag should be closed by some kind of a purse-string.

The need of a dressing or operating room is not essential. If there is only one ward such a room is advisable, but if there are several wards, one or more situated in first-floor wards will suffice.

In every ward should be one or more bathrooms, provided with a tub. Many new patients have bed baths, for they are too ill for a tub bath, so that a single tub suffices for admitting and discharging. For the convalescent, one or more tubs are a convenience. Tub bathing, in hospitals, however, is not to be encouraged in children, even in the same unit unless the tub is washed out between baths. In fact, patients suffering from different diseases may use the same tub if the tub is carefully washed out between units. Bed bathing for small children and babies is quite as convenient as the use of a tub.

In a good-sized ward of from 25 to 30 patients, an admitting room is useful. It must be equipped with lavatory and two hooks for gowns. In small wards or wards with single rooms, the patient might just as well be admitted directly to the room. The idea of having a common admitting room for several wards is not to be recommended unless the hospital is a large one which could afford to maintain a nurse there constantly, and unless the room is so situated and connected with the wards that few people would be likely to be near during transportation.

It is of great importance to provide veranda space for such cases as need open-air treatment and for the convalescents who are up and about. The objection to a veranda on both sides of a building is that it makes the rooms dark. This is a more or less serious objection. It is well, at the end of a building, to build a piazza for convalescents from the same disease—or this may be subdivided for two diseases. It is not necessary to provide veranda space for each bed all of the time, even for the acute cases. If the corridors are not less than 7 feet 6 or 8 inches wide, and the doors 3 feet 8 inches wide, when the beds are on wheels the patient may be wheeled to any other room or piazza if necessary. So that a veranda at the opposite end of the ward or one extending out from the side, perhaps leading to some other building, can by this measure be easily utilized for all such patients as require open air.

Whether verandas are provided or not, the rooms should have plenty of light and be so arranged as to furnish cross-draft as much as possible.

The problem of visitors to a contagious hospital is a difficult one. One use to which a balcony can be put is to allow parents to see their children from the outside. A balcony on which patients are placed or a narrow one for visitors alone, should be approached from the outside, if on the first story, but a second story balcony should communicate with an interior stairway, so that the friends can go up the inside stairway, and out on the balcony. This matter will be spoken of again in a later article covering management.

An open balcony without covering should lead from every utility room. It has been found that rubber goods, etc., if washed with soap and water and hung out in the air and sun are never a source of contagion. There is no need of sterilizing clothing except underclothing; airing and sunning is quite sufficient. These airing balconies are very useful for such purposes as well as for a place for brooms, mops, and similar articles. They should be carefully planned as to size and construction so that provision will be made for these things and for hanging up clothing, with shelving for rubber goods and utensils, and lines for rubber sheeting, etc.

The heating and ventilating problem of a contagious hospital differs in no way from that of a general hospital. Since most of the patients are children it is important in cold weather that there be an automatic regulating system for heat. Children can not always be kept covered and the rooms must be kept warm enough to insure that they will not be chilled. Either the direct or indirect system may be used, but if the former is employed, the radiators should be recessed and protected or placed high to save burning accidents. The direct type of heating demands a ventilating system. In the warm weather, however, open-window ventilation is to be advised.

The material used for construction is not essential. Permanent construction is advised if funds are available as it is less expensive in a long period of years. The material for interior construction likewise should be durable but not elaborate. A hospital for infectious diseases may be ever so beautiful and attractive, but the results of treatment depend not on this but upon the interior arrangements, equipment, and particularly

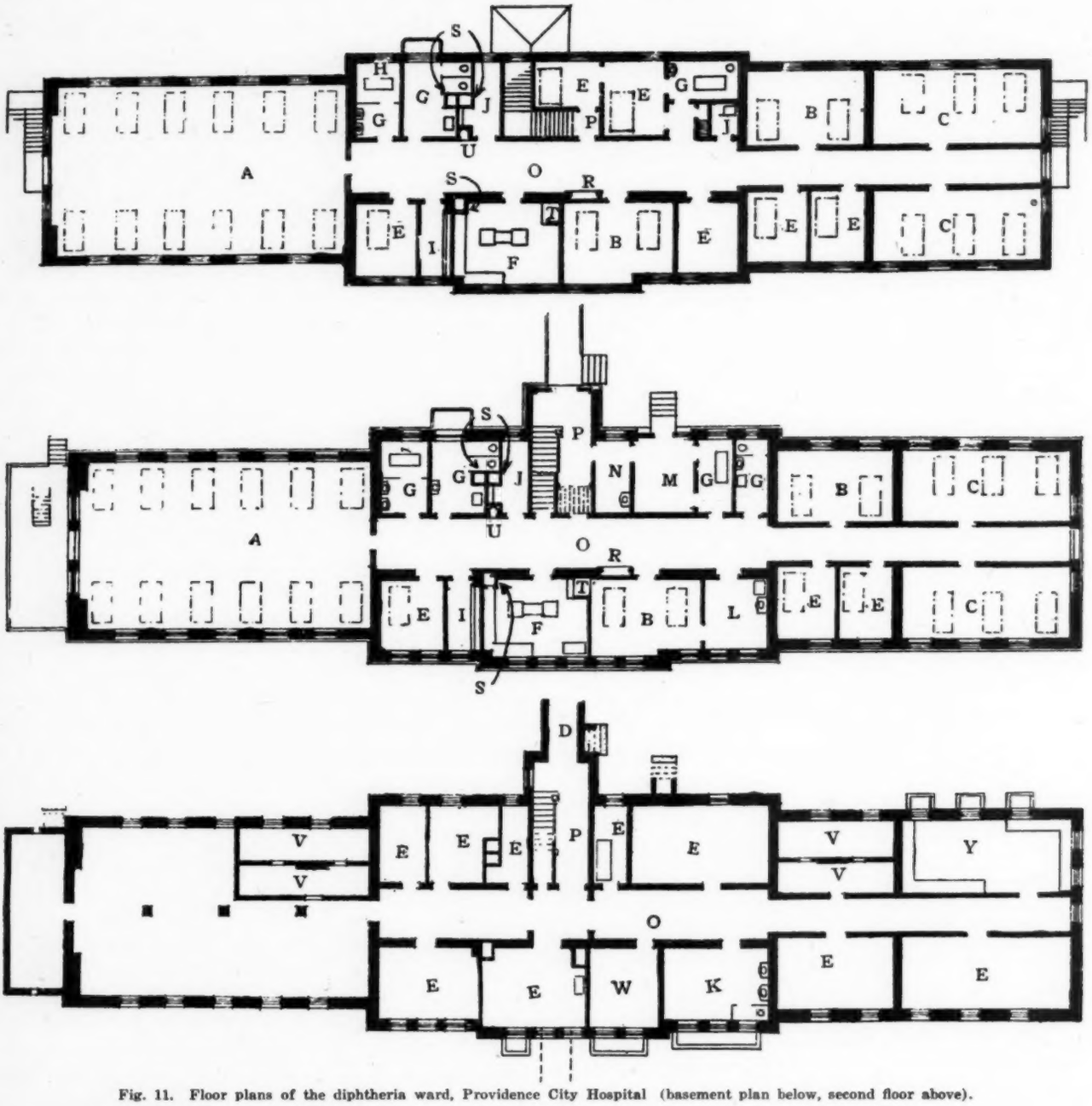


Fig. 11. Floor plans of the diphtheria ward, Providence City Hospital (basement plan below, second floor above).

A. Twelve-bed ward.
B. Two-bed ward.
C. Three-bed ward.
D. Tunnel.
E. Room.
F. Diet kitchen.
G. Lavatory.
H. Bath.
I. Linen closet.
J. Closet.
K. Nurses' clothes room.
L. Operating-room.
M. Examining-room.
N. Robing-room.
O. Corridor.
P. Stair hall.
R. Medicine closet.
S. Dryer.
T. Dumb waiter.
U. Chute.
V. Heating chamber.
W. Patients' clothes room.
Y. Laboratory.

upon the intelligence and faithfulness of its managers and its personnel.

The ward buildings may be one or two stories high, depending upon the number of patients it is necessary to build for. Where land is very valuable, as in the center of the city, a many-storied building may be used. The general arrangement of the wards and their position in relation to other buildings, need not differ from a general hospital. The administration and service offices and laundry facilities should be centrally located. All buildings, except possibly the ambulance station, should communicate by underground tunnel and there should be overhead walks for use in the warm and fair weather. The underground tunnel has been looked upon as means of dissemination of infection by connecting different buildings, each perhaps containing different diseases. This fear has no foundation in fact. At the Providence City Hospital such tunnels have been in use for ten years. They are very essential for the distribution to and from the wards of food and supplies and for the convenience of the personnel.

The nurses' quarters and quarters for the help

may be combined with the administration and service sections, but it is far better to put them in one or two buildings by themselves where the individuals can have better opportunity to enjoy something approaching home life. In small hospitals they may be housed in the same building; in larger hospitals, in two or more. Each individual should have her own room for two reasons: for privacy, and to reduce opportunity for contact in case of infection. They may all live in the same home regardless of the ward they are working in.

The nurses may all eat in a common dining-room, and the other help in another. This is entirely feasible, providing the technique is properly observed. It makes the nurses and help more contented, for their freedom is not taken away by shutting them up in their respective wards.

The accompanying table of disease among all employees at the Providence City Hospital covers eight years. The first column of figures refers to the number of different individuals who have worked in the various capacities. Individuals who have occupied more than one position have not been counted twice:

SECONDARY DISEASES AMONG EMPLOYEES: 1911-'18

Employees	Number of	Diphtheria		Scarlet Fever		Measles		Rubella		Mumps		Influenza	
		Number	Per cent of attack	Number	Per cent of attack	Number	Per cent of attack	Number	Per cent of attack	Number	Per cent of attack	Number	Per cent of attack
Ambulance attendants	3	...	...	...	...	...	...	...	...	...	...	1	33.3
Ambulance drivers	7	...	...	...	...	...	...	...	...	...	...	...	....
Attendant nurses	60	1	1.6	...	...	...	...	...	...	...	...	...	....
Engineer's dept.	19	...	...	...	...	...	...	...	...	...	...	...	....
Druggists	2	...	...	...	...	...	...	...	...	...	...	...	....
Graduate nurses	76	3	3.9	2	2.6	...	...	1	1.3	1	1.3	4	5.2
Housemaids	26	1	3.8	...	...	...	...	...	...	...	...	...	....
Housekeeper	1	...	...	...	...	...	...	...	...	...	...	...	....
Kitchen employees	69	...	...	...	...	...	...	...	...	...	...	...	....
Laboratory assistants	12	...	...	...	...	...	...	...	...	...	...	1	8.3
Laundry employees	45	1	2.2	2	4.4	...	...	...	...	...	...	1	2.2
Laborers (outside)	29	...	...	...	...	...	...	...	...	...	...	...	....
Office employees	30	1	3.3	1	3.3	...	...	...	...	...	...	1	3.3
Orderlies	60	...	...	...	...	...	...	...	...	...	...	1	16.6
Out-Patient dept.	8	...	...	...	...	...	...	...	...	...	...	...	....
Physicians (resident)	57	3	5.2	1	1.7	...	...	...	...	1	1.7	1	1.7
Pupil-nurses	740	32	4.3	47	6.3	4	0.5	6	0.8	7	0.9	12	1.6
Seamstresses	2	...	...	...	...	...	...	...	...	...	...	...	....
Stewards and porters	100	...	...	...	...	...	...	...	...	1	1.0	...	....
Superintendents and assistants	5	...	...	...	...	...	...	...	...	...	...	2	40.0
Superintendent of nurses and assistants	5	...	...	...	...	...	...	...	...	...	...	...	....
Waitresses	45	...	...	...	...	...	...	...	...	...	...	...	....
Ward maids	106	1	0.9	1	0.9	...	...	...	...	...	...	...	....
Total	1507	43	2.8	54	3.5	4	0.2	7	0.4	10	0.6	24	1.5

In only two or three instances had we any reason to believe that a nurse contracted a disease from another nurse either in the nurses' home or in the dining-room. It will also be noted that the nurses show the highest percentages of attack, the graduates nearly as high as the pupils although it must be remembered that while the graduate may have been in service years, the pupil only remains two or three months.

The laundry of a contagious hospital should be a generous one. In no other kind of a hospital is there so much linen to be washed. One item alone, hand towels, may amount to hundreds or thousands in large hospitals. It is not wise to place severe restrictions on the amount of linen to be used, because of the danger of its use by the nurses on patients in different units. The essential features of a good laundry pertain as well to those of any hospital, namely, good light, ventilation, accessibility, and the arrangement of the laundry machinery in such a manner as to make the process orderly and progressive. Many hospitals sterilize their linen before washing, or use sterilizing washers. In the latter instance, a separate sorting room is provided where the linen can be placed in the double-headed sterilizing washer, the other end opening into the clean washing room, or a non-sterilizing washer, one with openings on two sides facing into the infected sorting room and one on the clean side. This is perhaps a good plan in very large hospitals but is not necessary in smaller institutions. The key to success in laundering of infected linen is the way it is handled during collection and washing. Methods used in a commercial laundry are not satisfactory or safe, but if the washing is done with water at a temperature of 95 degrees or thereabouts, all organisms, except perhaps some spore-bearers, are killed. Careful bacteriological tests made at the Providence City Hospital substantiate this. Methods of handling infected clothing will be dealt with in a later paper.

A sterilizing plant should always be provided. The sterilizer should be large enough to take one or more mattresses, depending on the size of the hospital, and to it should be attached a formaldehyde apparatus for running formaldehyde gas into the chamber instead of steam when the use of steam would damage the articles to be sterilized. The sterilizer may be placed in one room, one side of which is reserved for infected material and the other for it after sterilization. Another method is to put a double-headed sterilizer through the wall of two non-communicating rooms, one for the infected room and the other for the clean room. It should be accessible by tunnel, if possible, to facilitate collection and delivery, especially during inclement weather.

There need be no particular features of construction of the ambulance station. The expense of a sterilizing room for ambulances is not necessary under a system of strict cleanliness.

The same is true of the main kitchen and supply rooms. There are no special features except

possibly a sterilizer for utensils that must necessarily be exchanged between the main and ward diet kitchen. If, however, the diet kitchens are provided with sterilizers, the cleaning can be done in them, saving the main kitchen the work.

So far as construction is concerned, the relation of the infectious wards to a general hospital need be no different from their relation to other parts of a complete infectious disease hospital with one exception. The infectious disease wards should be set apart from the main plant, not any particular distance but that it may be possible to control entrance of persons who rightly belong there and keep the patients from wandering to other parts of the hospital. If patients are allowed out of doors during convalescence it is feasible to have one or more separate playgrounds for those suffering from separate diseases.

LITTLE JOURNEYS TO PLACES "OVER THERE"

L'Hopital Hospice de Dreux—A Modern Hospital in a Beautiful Old Historical French City—Le Chateau de la Fontaine Bude—Where French Tuberculous Soldiers Are Cared for by the American Red Cross

By MARGARET J. ROBINSON, R.N., With the American Red Cross, Paris

TWENTY years ago, in the city of Dreux, a substantial residence with gardens and orchards was given to the municipality for use as an *asile des vieillards*, or old people's home. Community hospitals in France and on the Continent are frequently of this type, as hospitals are still used for the most part by the old and the poor, being, as a rule, charitable institutions rather than general hospitals.

The maire and the civil administrators of the city, during the few years previous to the war, happened to be men of progressive tendencies and men who took a vital interest in public welfare. Through their efforts, a subvention of 500,000 francs was obtained from the government, and, with the 400,000 francs of the endowment and surplus funds of the old hospital, construction was started for a new "hôpital mixte" at Dreux.



Fig. 1. The Door of Hope.



Fig. 2. View of the administration building and the Pavillon Franco-Americain.

On October 26, 1913, the hospital was formally opened under the auspices of M. Raymond Poincaré, the president of the French Republic, and, fortunately for France, was completed and ready to receive patients before August, 1914.

In peace times the hospital is prepared to care for 200 medical and 200 surgical patients. At present it is almost all military, having 510 military beds and only 150 civil. During the stress of the drives on the western front, by the addi-

tion of tent capacity, 780 military patients were cared for at one time. The hospital is now one of the best reconstruction laboratories in France, doing constant and splendid work in the task of making the maimed well again.

The hospital buildings at Dreux are on high ground, raised above the main roads on the one side and over a small river valley on the other so that they have good space for air and light and a good position for drainage. The buildings stand about a court and formal gardens.

The administration building, first seen from the street above the terrace, contains offices, laboratories, and the Franco-American dispensary. Going through this building, one enters on the garden court. At the right is the terrace over the river valley, and at the left the "pavillon Franco-Américain" and the building for physiotherapy. On the opposite side of the court from the administration building is a broad archway joining the medical and surgical buildings. Beyond this archway are pleasant gardens. On the left of these are the kitchen buildings. Facing the gardens is the maternity building, which is the old residence, formerly the original old people's home, and on the right below the terrace is the service building.



Fig. 3. In the waiting room of the Franco-American dispensary.

The staff administration of the hospital is in the hands of a *médecin chef* and his corps of assistants who are surgeons and medical men, specialists in contagion, physiotherapy, radiography, and branches of special medicine and surgery. All are military medical officers. The administration of the Franco-American pavilion and dispensary is in charge of both French and American personnel. The staff for the work on tuberculosis is largely from the Commission for the Prevention of Tuberculosis in France (Rockefeller Foundation). Material assistance in building and supplies has been received from the bureau of tuberculosis of the American Red Cross.



Fig. 4. Four patients—soldiers of France—a Senegalese, a Moroccan, a Tunisian, and an Algerian.

American assistance has been given to this hospital, as it has been given to other hospitals in France for the care of the tuberculous, because of the gravity of a situation due to the increase of this disease among both the civil and military population.

It has been estimated that from 70,000 to 100,000 French soldiers have been found tuberculous. The facilities for the care of the tuberculous have been taken over for them by the military authorities. This left practically no facilities for the care of the civilian population. Added to this unfortunate condition, there are 5,000,000 refugees in France, displaced from their homes and scattered throughout the country. Among them are many tuberculous who are a menace to the districts they occupy.

The Commission for the Prevention of Tuberculosis in France and the American Red Cross, realizing the gravity of this situation, have given assistance to already existing hospitals to care for the tuberculous and have established Franco-American dispensaries in various cities and towns which are centers of population. The Franco-



Fig. 5. The air porch of the children's floor in the Franco-American pavilion. The médecin-chef and his French and American assistants.

American pavilion has three floors of separate service, for men, women, and children. All the wards are large, well-ventilated, and well-lighted, and each floor has its own air porch. The nursing care is given by the Sisters of Saint Paul du Chartres, who have charge of all the nursing care of the hospital. This order, which has its mother house in the famous old cathedral city of Chartres, is one of the great nursing orders in France, with branches in both Italy and Japan.

In the Franco-American dispensary, of which some illustrations are given here, both French and American doctors give thorough physical examinations to all patients applying for treatment. The nurses of the dispensary are French aides who have been trained under American nurses.

I happened to visit the Franco-American pavilion just a few days after Christmas, and the children's floor was still having holiday. The tree with its trappings was still in the center of the ward, and toys sent by the American Red Cross were still wonderful and would be wonderful as long as a rag of them lasted. It was chocolate time, and big grandfather's cups of chocolate were being passed around.

I had been to the pavilion a month before, and already could see the change in several of the children who had entered in poor condition. Small, thin bodies were rounding out. Cheeks had changed from yellow to pink. France needs every one of her babies to replace her millions of dead and mutilated and physically exhausted.

The physiotherapy building is a very busy center of the hospital. In one room the masseurs work over arms and legs which have lost function through various sorts of wounds. During my last visit when I was in this room several colonials, Senegalese, Tunisians, and Moroccans were among the patients.

The physiotherapy building is equipped with a completely furnished Zander room for the manipulation of joints and muscles, a hydrotherapy department, and radiographic laboratories for

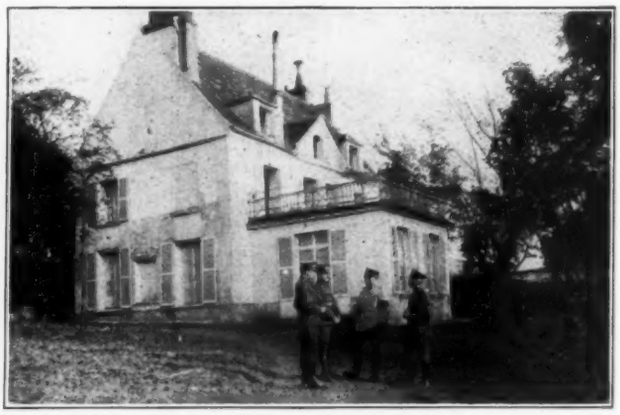


Fig. 6. The old Château de la Fontaine Budé, the home of the personnel. (See pp. 122-3)

both radiography and radiotherapy. As a large part of the hospital patients are under physiotherapeutic treatment, the waiting rooms are full of soldiers awaiting their turn. The surgical pavilion has large wards for military patients who are in need of further dressings or operation.

The buildings, all well-constructed, have good sanitation, light, and air, and polished cement flooring. An operating service is also in this building, and each floor has its own dressing room. In the center of each ward is a modern dressing carriage with tanks for running sterile water.

The medical building is of the same construction, and its wards have both civil and military patients. Each ward has its own dining room for convalescents.



Fig. 7. The reconstructed château and porches (See pp. 122-3)

Beyond the medical and surgical pavilions, in the old garden, there is a small service building known as the *cuisine*, where all the food for the hospital is prepared. The building has food storerooms and a white-tiled kitchen, about 20 by 35 feet. In the center are large stoves, each with great copper pots set into the stove itself. The day I visited the *cuisine*, the floor was being washed by two of the sisters, two Boche prisoners, and two French convalescent soldiers. The soapy water was poured on the floor, and the kitchen personnel of six then swept it out of the door and over the walk into the gutter, with long, loosely woven brush brooms.

As we entered the maternity building at the back of the garden, which is the old residence, we were greeted on the porch by a cooing dove in a big wooden cage. The building is in good condition and is kept very clean. There are no sisters or trained nurses in this building. The obstetrical nursing is in charge of a *sage-femme*, or midwife, and her assistants, who do not even wear cotton uniforms. There is no nursery. The babies are in cribs, each beside the mother in the ward. No air is allowed in the room with the mothers and babies.

Below the terrace on the right there is a contagion pavilion and service, the latter now in use for sick Boche prisoners.

The service building contains the steam plant, disinfecting plant, and laundry. The laundry is equipped with some modern machinery, such as washers, wringers, and other things. The drying is still done on racks, and the washing process is still started in the washhouse on the little river.

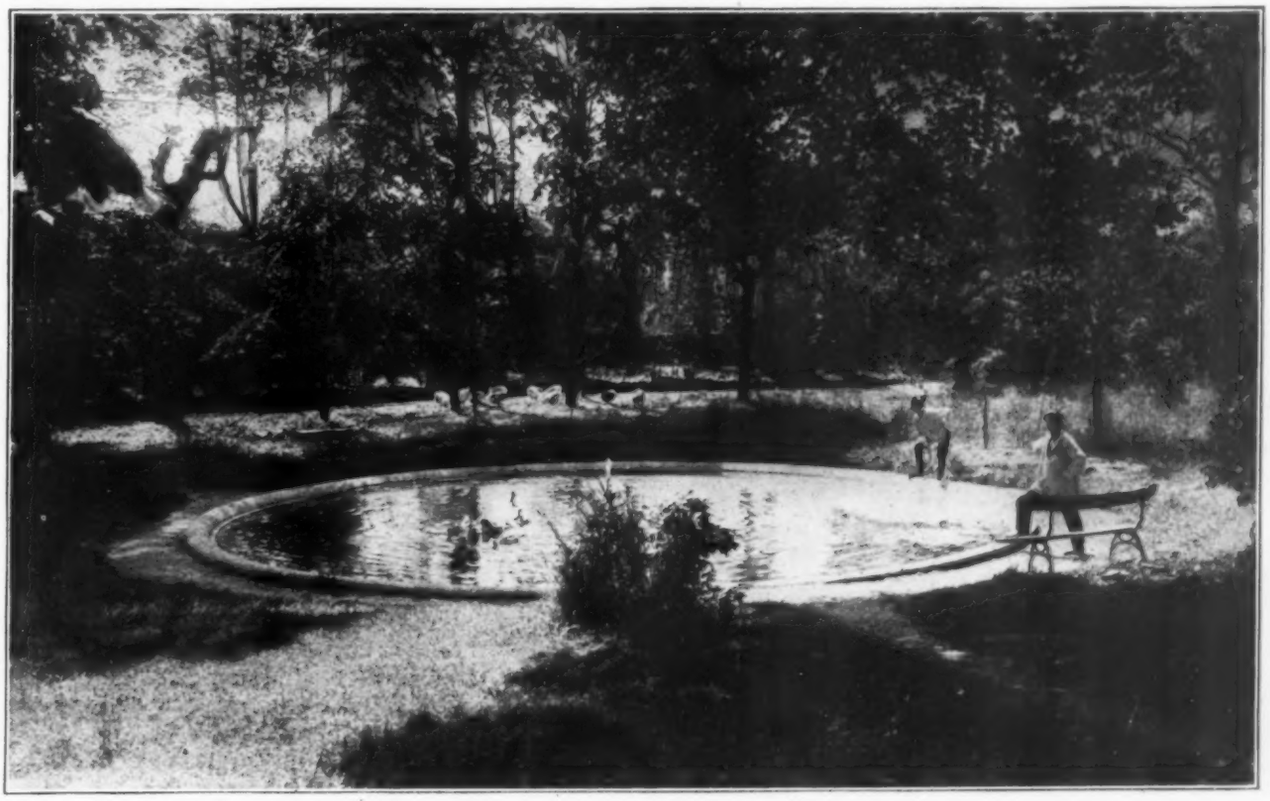


Fig. 8. The fountain that plays forever and gives the Château de la Fontaine Budé its name (See pp. 122-3)

The clothes are first dipped in the river and then scrubbed on the boards and stones at the edge.

The Dreux hospital—beautifully situated, well-constructed, and one of the most modern hospitals in France—is a strange mixture of the best modern hospitalization and the primitive traditional Continental methods. It has made great strides beyond many other hospitals in France and has done an invaluable work for France in the care of its wounded of the war. Perhaps to American eyes and ideals its greatest need is for trained women, graduate nurses, and a school in which these women can train others to come after them. Perhaps some day this too may enter its doors, and then with the fine things and the fine spirit it already possesses, the hospital will be an impulse and an inspiration for France to be proud of and to imitate.

To the Château de la Fontaine Budé

We first went to Yerres last autumn when the trees were blooming in soft browns and mauve and gold, and there were pictures everywhere in the vistas through the even rows of formal trees that bordered the roads we motored through. Then the gardens were colored with foliage and fall flowers and the potager had all sorts of green stuff in it that was good to eat. Then, as we entered the gates past the house of the concierge, we saw the round stone fountain pool that always throws its circular stream of water heavenwards, and near the entrance porch of the château was a convalescent poilu in blue, sunning himself, perched on an old sundial, and caressing a tortoise-shell cat. On each side of him was a carved marble jardinière filled with blood-red geraniums. Through the pines and linden trees, a tinseled red setting sun shone like a ball on a Christmas tree.

This time we went out to Yerres in January. The houses and gardens we passed reminded one of the diamond-dusted scenes on old-fashioned Christmas cards.

Again we passed through the gates by the house of the concierge. A man in blue, a small bare-kneed boy, and a women with a black knitted cape over her shoulders came out to greet us with a cheery, "Bonjour, Messieurs et Mesdames."

The château is on high ground, and the road winds higher and higher as you get to it. It is four hundred years old, most beautifully situated and beautifully constructed and surrounded, but, like most of these old places, it was lacking in the ordinary modern conveniences and sanitation, and, when the American Red Cross took it over for its present purposes, it was necessary to install central heating, lighting, and modern plumbing. Outdoor treatment for tuberculous patients was assured by the addition of broad verandas along the front of the three floors of the main building. At present, the château, as the Hôpital Croix Rouge Americaine, is accomplishing a splendid work for these *blessés de tuberculose,* this pathetic group who have little of the glory of the wounded hero, and who receive less of the

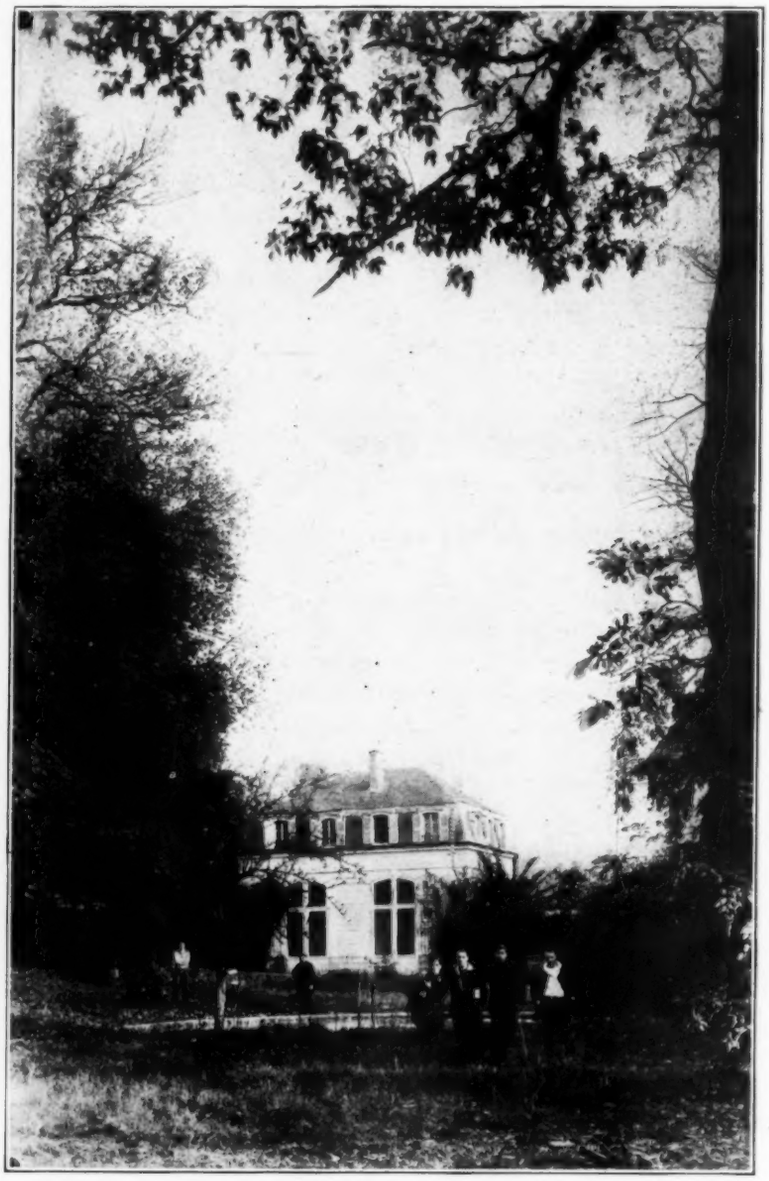


Fig. 9. A view of the orangerie that is now a laboratory, and some of our patients.

pride and sympathy of family and friends. There are many such in France and few facilities for their care.

The high-ceilinged rooms, long French windows, and sun porches, with the addition of the modern equipment which has been installed, makes of the château an ideal sanatorium for the care and treatment of tuberculosis. The patients received are the French soldiers known as "Réformés No. 2," men who cannot return to further military service. Those whose illness is not too far advanced when they are received into the hospital for treatment are gaining constantly in strength and weight with the best of medical and nursing care, the good food furnished by the Red Cross, and the open air afforded by the château and its beautiful surroundings. Those who are worn by the disease before coming to Yerres, are given care and comfort until the end of their journey. Then, too, when that journey ends, the Red Cross sees that they go to rest with all the quaint religious ceremony of their church and country, even to the lumbering fringed and draped funeral carriage, the walking priests and mourners, and the wreaths of purple beads or many-colored flowers.

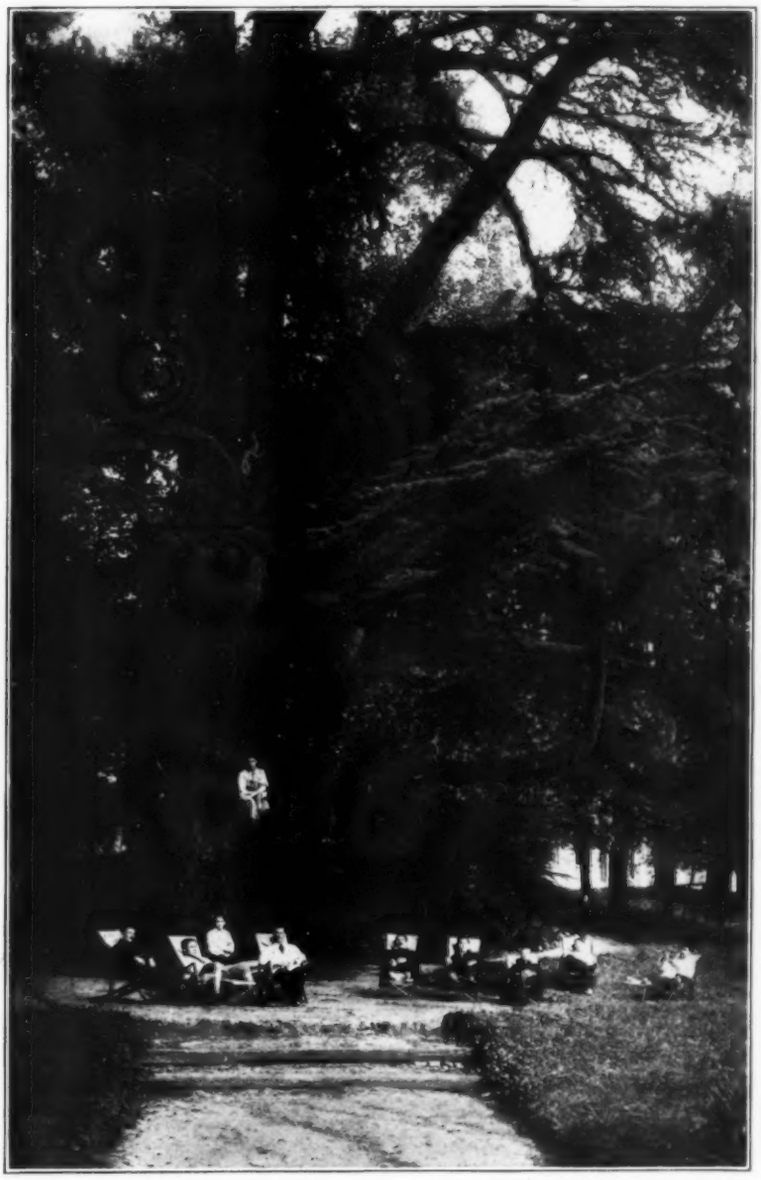


Fig. 10. The giant cedar of Lebanon which makes shade for *les blessés de tuberculose.*

The château hospital is administered through the bureau of tuberculosis of the American Red Cross by American doctors, nurses, and nurses' aids. The nurses' aids are doing valuable work with the convalescent patients and also act as interpreters for the household. The ménage is in the hands of a French housekeeper and maids, which tells without saying that the meals are well cooked and the buildings clean and orderly.

The porches and wards are arranged to care for eighty-five patients. The day we visited Yerres, there were rows of chaises-longues on the porches, each one with a poilu in it, well-wrapped in blankets and mackintoshes; mere boys most of them were. They had apparently lost their characteristic national fear of a *courant d'air,* and were enjoying the cold. When the dinner gong sounded, there was a rush for the dining room, and it did not take long to empty the plates of all the food in sight.

Upstairs, the open wards were filled with hospital beds, hospitals beds with pink bedcovers. There were a number of bed patients. All the windows, which reached from the floor to the ceiling, were opened wide. The bedside tables had all sorts of little personal belongings on them and the handwork that some of the patients who were able were making. Everybody seemed to be having a good time. The American nurses and aids look upon their soldier patients as just big children. The château is still a family residence.

When the American Red Cross finishes its hospital work in France, which will be within a few months now, the château will be turned over the French government organizations to continue the work among its tuberculous soldiers—truly a generous gift to France and her long-suffering soldiers, from a friend who understands her need.

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The Growth of the Hospital Idea

Figures in a recent official report to the U. S. Department of Labor show the astounding growth of the hospital idea in this country during the last half-century. In 1873—less than fifty years ago—there were in the United States only 149 hospitals; today there are nearly 9,100—an increase of nearly 6,000 per cent in the number of institutions. In 1873 the total bed capacity of the then-existing hospitals was 35,453; today the hospitals of the country have a total capacity of approximately 869,000 beds—an increase of over 1,000 per cent. The amount of money at present invested in these institutions is roughly estimated at nearly two billion dollars; the annual expenditure for supplies, equipment, upkeep, and new construction is said to be about three-quarters of a billion.

There is much that is gratifying in these enormous totals. Certainly, no stronger testimony could be adduced to show that the people of the United States are thoroughly converted to the hospital idea, and do not mean to be deprived of the benefits of hospital care. So far, this is good.

Sober second thought, however, discovers some rather formidable questions in this staggering mass of figures. How much of this vast hospital investment has been wisely made and how much of it is destined to be a dead weight on the development of the future? In how many cases have the needs of the community been carefully surveyed before the hospital was even planned and in how many cases has the plan scarcely gone beyond the feeling, "A hospital is a good thing. Let's have a hospital." A two-hundred-and-fifty-bed maternity hospital is erected, and by the donor's will devoted in perpetuity to this single use, in a community in which the total annual births would never keep the beds filled; a four hundred-and-fifty-bed epileptic colony finds less than a hundred inmates; and meanwhile other institutions are forced to turn patients away. Here and there is a general hospital equipped with an elaborate and costly operating room, but inadequate laboratory facilities, in a community in which surgical cases are few but cases of typhoid and malaria abound. Hospitals to this extent victimized by the misdirected benevolence of their founders are rare, it is to be hoped; yet, on the other hand, the idea that a hospital is a hospital is so general that hospitals carefully adapted to the needs of the communities which they are intended to serve are probably not very common. Everyone realizes that a shoe may be very well made, of the best material, and according to the best designs, yet totally unsuited to the size and shape of a given foot and to the use desired. The principle that a hospital should be as carefully fitted to the needs of a community as a shoe is to the foot is so new, however, that probably in the majority of instances, when a new hospital is to be built, a well-meaning contributor or local committee sets out to collect "ideas" from hospitals held up as models, giving only secondary thought, if any, to the question whether these hospitals are adapted to the same local needs.

A second consideration emerges from the examination of the figures above referred to. The total hospital bed capacity of the country has increased enormously, yet relatively much less than the number of institutions. The average number of beds to an institution in 1873 was 238; today it is a little over 98. Moreover, the absolute size of the large hospitals has increased also. Mount Sinai, New York, for instance, in 1868 could "accommodate about sixty patients comfortably"[1]; its present capacity is 500. Pennsylvania Hospital in 1867 had 155 patients; it now can take care of 315. Since the increase in the total number of institutions has been great relatively to the increase in total bed capacity, and since the increase in the bed capacity of the large institutions has been absolutely great, therefore, it fol-

[1] Cammann, Henry J., and Camp, Hugh N.: The Charities of New York, Brooklyn, and Staten Island, Hurd and Houghton, New York, 1868.

lows that the increase in number of small institutions must be enormous, and that the vast majority of hospitals in the country must be well under one hundred beds capacity. Furthermore, the idea of making a survey of the community before building a hospital, has found lodgment, if anywhere, in urban centers, and application to the foundation of large hospitals. A large institution can afford to employ a hospital expert, or a corps of experts, to make preliminary surveys before the plans are drawn. This is obviously out of the question for rural communities and small hospitals. The consequence is that, though small hospitals are in the vast majority, there is almost no collected and organized knowledge of their needs, particularly the fundamental needs concerned with their relation to the community.

The moral seems to be twofold: In the first place, there is still need for missionary work in spreading the hospital idea, but this missionary work needs to be directed now, not so much to convincing people of the value of hospitals as to teaching them the necessity of measuring the needs of the community before building or even planning a hospital. In the second place, since small hospitals so greatly outnumber the large institutions, and since cross-roads communities will never be able to command the service of high-priced hospital experts, the crying need of the hospital situation today seems to be for an investigation of the hospital needs of various rural communities, with a view to discovering some general principles which may be applied in any specific instance. In no other way, apparently, shall we solve one of the most important, if not the most important, hospital problem of the present day.

A Noteworthy Measure for Promoting Dispensary Efficiency

A certain hospital has posted on its walls the following motto:

"Who is to be considered first in this hospital? *The Patient.*"

Of course the patient is the first consideration in every hospital that is worthy of the name, one naturally thinks. What else is the hospital for? Is not the welfare of the patient the whole object of the institution? Or can it be, after all, that the cure of the case sometimes obscures the welfare of the patient? For the cure of the case and the welfare of the patient are not always precisely synonymous terms.

In a dispensary, for instance, where, as Dr. Edwards A. Park observes, it is generally assumed that it is better for many patients to lose an aggregate of hundreds of hours than for the physician to run the risk of losing a few minutes,[1] it may well be questioned if the welfare of the patient is the first consideration. For, to the very poor, even when medical service is provided free, it often becomes a serious problem whether the physical trouble is a worse ill than the loss of time and wages necessary to get it treated.

It is a very hopeful fact that the simple common-sense device of making appointments for dispensary patients, just as if they were private patients, thereby saving the time which wage-earning people can so ill afford to lose, has been found to work out satisfactorily for dispensary physicians, whose time is, in fact, conserved rather than wasted thereby. Although Dr. Park's paper describes work done in a children's dispensary in France, the principles which it sets forth are entirely applicable to dispensaries of all classes everywhere. Perhaps there may be other lessons suitable for civilian use in the war experiences of other hospital people. If so, we shall be glad to hear from them.

The Use of Milk In the Hospital

Since milk is now being sold at a price which is almost prohibitive so far as the smaller hospital and the families of limited means are concerned, it behooves both the hospital and the home to give a little more thought to its use. Even at the present cost, milk should not be eliminated from the diet, particularly of growing children, but we venture to say that in 75 per cent of the hospitals of the country it could be used more effectively and less extravagantly than is at present being done.

The value of skimmed milk has never been fully appreciated in hospitals. It has practically all of the food value of whole milk except the fat. Reducing the fat intake of the body to this extent will in very few cases be a serious deprivation and it can easily be made up in other ways, particularly in the diet of the nurses, interns, and employees. For cooking purposes, skimmed milk may be used with very satisfactory results. At this season of the year the fat and food accessories could, and might just as well be furnished by the use of green vegetables and vegetable oils either cooked or in the form of salads. If milk is furnished as a beverage to hospital people it can well be skimmed milk.

The difference in the price of whole milk and skimmed milk will be a decided saving if used in this way. Or if a hospital prefers to buy the

1. Park, Edwards A., and Co-Workers: The Organization of a Children's Dispensary on the Basis of Appointments for Patients, THE MODERN HOSPITAL, this issue, page 101.

whole milk and skim it, that can also be done to advantage, provided it is done properly. In following the latter method, the whole milk is available for children and other patients needing it without having a separate supply. Even in those instances where milk should be used, it may be supplemented, and thereby the amount be decreased, by a gruel of oatmeal, cornmeal, or other cereal, to which has been added a little cream, beef broth, or fruit juices. These give to the gruels a pleasant flavor and help to relieve the monotony of liquid diet, and at the same time add to the nutritive value.

The ordinary sick person requires a food which is liquid, and therefore easy to take, one that is without strong flavor, and easy to digest; the hospital requires that it be as inexpensive as possible and easy to prepare. It need not supply a large amount of nutriment in cases of brief illness or in instances where the patient may have custards, eggs, and other highly nourishing foods.

LULU GRAVES.

Two Books You Want to Know

One's first impulse, after reading a new book by Dr. Richard Cabot, is to tell some one else to read it. The blend which his writings present of ripened wisdom and friendly, companionable charm, of utter unpretentiousness and deep sincerity, is unique, so far as we know, and it seems selfish not to share it with some one else at the first opportunity. The two books now at hand, "Social Work"[1] and "A Layman's Handbook of Social Medicine,"[2] are intended for social workers, but it would be most unjustifiable for social workers to keep two such books to themselves, for both are not only delightful to read, but most helpful in the thoughtful solution of the problems of living which none of us can escape except by the unwelcome expedient of dying.

Frankness and simplicity, without a trace of professional condescension toward the layman, mark Dr. Cabot's writing. He puts on no mystic, medicine-man's robes and performs no incantations to keep the profane at a distance—in which, after all, his attitude is that of the scientist as opposed to that of the shaman. "A little knowledge is a dangerous thing," he quotes in the preface to "A Layman's Handbook of Medicine," and goes on to answer, "Yes, it certainly is. But since every body and soul in the civilized world has now been thoroughly exposed to this dangerous contagion, I know no way to reduce the risk of disaster, except by injecting into all who will submit a larger dose of knowledge in the least irritating form procurable. Gradually I hope an immunity to its dangers may thus be produced."

"A Layman's Handbook of Medicine" discusses within the compass of a little more than five hundred pages "Anatomy and Physiology," "Diseases of the Respiratory System," "Diseases of the Heart and Arteries," "Diseases of the Gastro-Intestinal Tract," "Diet—Constipation," "Diseases of the Liver and Intestines," "Diseases of the Kidney and Bladder," "Diseases of the Generative Organs," "Diseases of the Nervous System," "Diabetes," "Diseases of the Blood," "Diseases of the Bones and Joints," "Diseases of the Muscles," "Infectious Diseases," "Poisons," "Industrial Diseases—Skin Diseases," "Diseases of the Eye and Ear," "Emergencies—Home Medicine—Personal Hygiene," "Miscellaneous Ailments, Trivial or Severe." No one who knows Dr. Cabot's writings needs to be assured that, in spite of the great range of subjects covered in this book, it is neither dry and tasteless on the one hand nor cheap and slipshod on the other.

Probably some will ask what need there is for a "layman's handbook of medicine" at all. Isn't the layman better off without any knowledge of medicine except such as his family physician may think best to impart? The answer to that is partly contained in the extract which we have quoted from the preface. Most laymen do know more or less about medicine—and know it wrong. It is surely better that even laymen be immunized against gross medical superstitions and erroneous beliefs by a moderate protective dose of real knowledge. As for the family physician in the rôle of instructor, he is in the same class with the parent—theoretically the ideal medium of instruction, but actually too often a flat failure because neither nature nor training has prepared him to teach, even if his traditions did not lead him sometimes to look on medicine as a mystery rather than a science so far as the public is concerned.

"We never give people help that has any permanence in it except when we give them reality," says Dr. Cabot in "Social Work"; and that is why his books are truly helpful—because they are based on reality. Many years ago, he says, he swore off from medical lying—the benevolent, unselfish lying which physicians practice solely for the good, as they believe, of their patients. In a little book published some time since, "Social Service and the Art of Healing," he tells how he came to take such a radical step and what came of it. In "Social Work" he gives some further instances of the real tonic effect of the truth

1. Cabot, Richard C.: Social Work: Essays on the Meeting-Ground of Doctor and Social Worker, pp. 188, price $1.50 net, Boston, Houghton Mifflin Company, 1919.
2. Cabot, Richard C.: A Layman's Handbook of Medicine, pp. 529, price $2.25 ($2 net), Boston, Houghton Mifflin Company.

—of patients relieved of consuming, secret fears by the frank utterance of a truth which the physician might well have hesitated to reveal. After all, the screen which the kindly physician erects between himself and the patient may not only keep the patient from seeing into the physician's mind, but also prevent the physician from getting a true perspective of the patient's mind.

Dr. Cabot can afford to tell the truth, because he is a sturdy optimist who believes that the truth is good in itself. Even the "Layman's Handbook of Medicine" ends on an optimistic note. "Purely medical books do not end happily," he says, "but as this book is almost half human, it may well be rounded off with a consoling fact about disease, viz., *that it usually gets well of itself if given half a chance.*" Now, why shouldn't a book be nearly half human when written by some one who is quite four-fourths human?

"Carry Over"

When the history of the part played by the hospitals in winning the war is written it will be a record of no mean accomplishment, and one of which on the whole we shall have reason to be proud. The hospitals responded most loyally to the call to "carry on," more often than not sacrificing their own interests to the interests of the larger whole. Doctors, superintendents, nurses, and even whole hospitals gladly enlisted in the nation's service, and those who remained worked against great odds to maintain the services the hospitals were called upon to render.

Methods of economy were worked out and put into practice; food was saved; fuel was saved; gauze and a hundred other things were saved, savings which frequently redounded not only to the benefit of the nation as a fighting unit, but to the patients in the hospitals and to those who cared for them.

But now that the war is over and we are gradually turning our faces toward the pursuits of peace, are we not in duty bound to "carry over" into the years to come some, nay, many of the principles and practices which we learned during the trying period that we were called upon to "carry on." If it was wise economy then to save on drugs through a careful system of checking, appropriate tests and careful methods of distribution, is it any the less wise economy now? If careful technique of nursing could then be applied through the replacement of absorbent gauze with non-absorbent cotton and the use of washed and resterilized gauze, will technique seriously suffer if these and like economies are "carried over"? Dare we say that methods of food conservation worked out during the war may now be thrown into the discard as no longer applicable?

What, moreover, of the lessons in hospital construction and more important still in hospital administration that were learned by the men—laymen and physicians alike—who served here and abroad and who are resuming their places on our hospital staffs. Are we making every effort to "carry over" into the everyday life of our hospitals the lessons of undoubted value which they learned? Are we making the best use of their enlarged horizons and their knowledge born of an intense experience in order to strengthen and broaden our service? In a word, are we yielding to the temptation to slump, or are we firmly holding ourselves to a continued application of the best of the war economies and experiences?

The Winchester Hospital

One of the noteworthy things in connection with the story of the Winchester Hospital, told by the architect, Mr. Hill, on page 92 of this issue, is the fact that the building committee had the wisdom to consult the architects before purchasing the land. The experience of this hospital in the growth of the demand for maternity accommodations is general.

The block plan presents a number of very important questions. It would be interesting to know why, if Highland Avenue is the most important street, the main entrance was placed on the west side of the building, resulting in excessive (and probably expensive) drives, and the service portion of the building in the front. The physicians and all others in autos will use the basement entrance; the main entrance will only be used by visitors on foot. It is always advantageous to control the visitors as well as the doctors, by inducing them to pass the main office. There may be reasons, such as the outlook, or slope of the ground, which dictated the adoption of this orientation, but other things being equal it would seem to have been better to have faced the building around, that is, with wings to the west, or, preferably, to turn it at right angles, with wings to the south. It might have seemed preferable, also, to have the operating department so located that the patients who will be brought to and from the operating rooms will not be subject to the gaze of visitors and of the public entering the hospital through the main entrance; but the promise is made that it can be given another location in the future. It would improve conditions if a partition and doors glazed with obscured glass were built to separate the lobby from the main corridor.

OCCUPATIONAL THERAPY, VOCATIONAL RE-EDUCATION AND INDUSTRIAL REHABILITATION

Conducted by DOUGLAS C. McMURTRIE, *Director Red Cross Institute for Crippled and Disabled Men* and ELIZABETH G. UPHAM, *Advisor in Occupational Therapy, Milwaukee-Downer College.*

OCCUPATIONAL TREATMENT FOR THE INSANE

Dementia Precox Patients Show Improvement—State and Institution Benefit as Well as Patient—Work Promises Still More for Future

By CHARLES F. READ, M.D., Superintendent, Chicago State Hospital, Dunning, Ill.

Over 50 per cent of the patients in the state hospitals of Illinois, or of any other state for that matter, are cases of dementia precox. The salient feature of this type of mental disorder is a loss of interest in the things that serve as spurs to normal activity—desire to get on in the world, love of home and family, outside social interests, etc. Fantastic ideas and bizarre activities take the place of these sane interests, and the affected individual ceases to make the adjustments necessary to retain his place as a member of the family and of society at large. He gets out of step with the mass of his fellows; depends more and more upon his own delusional resources; contents himself with poorer and poorer ways of doing things; and in the end, if allowed to go his own gait, suffers a more or less profound deterioration.

Accompanying this mental degradation there is no corresponding physical decay, and, as a result, the precox patient who enters an institution at twenty may very well continue to exist there until he is seventy. At least 20 per cent of all commitments belong to this group, and, since so few die and so few recover (possibly 10 per cent), a balance between the incoming and outgoing is not struck until at least half of the entire hospital population consists of this type.

This sad statement is an admission of the fact that dementia precox remains the sphinx of psychiatry. We do not know the cause, although we may speculate upon it; finding no definite brain lesion, we can have no specific therapy. We can only do what has empirically proved to be successful.



Fig. 1. Bookbinding and basketry are taught in the occupational center.

The fact that occupation is good for disordered minds has been very definitely known for many years. Of necessity, the bulk of the routine work about a state hospital has always been done by patients under the guidance of employees. The majority of these workers are dementia precox patients and, as a rule they do not deteriorate beyond a certain point. They form the backbone, so to speak, of the hospital organization. They are interested in what goes on about them; they take pretty good care of themselves; they appreciate entertainments; and not a few are paroled home from time to time.

Here it is, then, that we seem to have the secret of some sort of treatment for this type of disorder and for many others as well. Occupy these people; give them back a definite interest, even though it be but a petty one compared with what they have lost. By this means furnish them a snug harbor where they may find anchor in place of drifting helplessly before the shifting winds of fantasy on a trackless waste of inactivity. We cannot expect a cure in very many cases but we can hope to make out of the former college instructor a fair hand at raising chickens; out of the stenographer, a good seamstress, etc. What has been thrown overboard in the storm of the acute psychosis can not be entirely replaced, but something can be salvaged and final shipwreck avoided in many instances. To accomplish this result in a great mass of patients—we have at least sixteen hundred precox cases in the Chicago State Hospital alone—it is obvious we can not depend entirely upon industrial occupation since this presupposes a remnant of initiative in the patient sufficient to permit of his employment under rather haphazard conditions. To be industrially effective he must apply himself to his appointed task with comparatively little guidance, once it is set plainly before him.



Fig. 2. Manual training for the insane at Dunning, Ill., brings decided improvements in patients' condition.

To create purposeful activity in a patient too indifferent to do any work of his own initiative is quite another mat-

ter and requires, in a large institution, a considerable organization and a definite program.

In the spring of 1918 the Department of Public Welfare of Illinois appointed Mrs. Eleanor Slagle, of the Favill School of Occupations, part-time director of occupational therapy throughout the state. In April a department was opened at the Elgin State Hospial and in June, at the Chicago State Hospial. Women of experience were secured as superintendents and voluntary workers were supplied from the Favill School of Occupations, women who had taken a two months' course of training in the school and were to round this out with three months' field work in a general hospital and in an institution for the insane. These women were college graduates, already trained to quickly grasp and assimilate new ideas and methods. The majority of them were pledged to government reconstruction service when called, and, at this writing, practically all of those who have completed this field work are in



Fig. 3. An old case of dementia precox making a hook rug.

government hospitals. Under the direction of Mrs. Slagle and the guidance of Mrs. Burns Tompkins, formerly of Danvers State Hospital, Mass., as superintendent of the new department, the work was rapidly organized at the Chicago State Hospital. A superintendent was placed in charge of the entire department, and an assistant (male) in charge of calisthenics, gymnastics, games and folk dances. Volunteer occupational therapists varying in number from six to ten (the students referred to above) gave their services, together with a few paid workers, to teach the patients upon the wards and in the occupational center.

The patients are prescribed for by the ward physician and placed at suitable occupations in classes in the receiving cottages and upon the observation and the deteriorated wards (six in all at present), where they cut out toys with coping saws and sandpaper and paint them; make reed baskets; weave netting; do beadwork; make hook rugs; construct dolls and dress them, etc. Over seven hundred patients passed through these classes during the first year.

Each group attends class in the morning and calisthenic exercises in the afternoon, or vice versa. Some patients must even be taught again the use of their hands, having apparently lost or mislaid the power of muscular coordination. Others can perform only the simplest movements such as sandpapering, unraveling tea matting, spool knitting, etc., and these for but short periods of time at first. Some can not even be persuaded, in the beginning, to do anything at all, but are allowed to sit near others who are working until they themselves in turn become interested or more susceptible to persuasion.



Fig. 4. A beginners' class in calisthenics. After a time they do much better than this.

Not all the patients handled in this way are dementia precox subjects. One of our most interesting cases, one of depression, was that of an Indian whose recovery was undoubtedly advanced several weeks or even months by occupational therapy, first in the ward class and later in the occupational center. Another similar case is that of a patient who is almost ready to leave after several months' treatment, though, in justice to the hospital ward, it must be said that in the earlier stage of her depression her life was saved by forced feeding and normal salt injections. In the receiving and observation wards it is the rule to bar out no patient on account of age or psychosis. The majority of these acute cases have been torn up by the roots, as it were, and rudely transferred from an active life to the deadly monotony of hospital care. If occupation were to do no more than serve them as a pastime during this period it would be of service. As a matter of fact, it accomplishes much more than this. The average patient begins to occupy himself immediately after admission and in so doing, not only retains what habits of industry and normal thought still remain, but gradually adds to this interest. Slowly he learns again the lesson of orderly achievement, learns to control his energy and accomplish little tasks. Having learned the lesson in a small way, he is the better fitted to undertake larger tasks and may ultimately find himself again fit for the complicated problem of getting along in the outside world.

When the patient has sufficiently improved in the ward class he is promoted by the physician and goes to work in the occupational center—formerly an old power plant. This building in itself is a good example of reconstruction



Fig. 5. The carpenter shop, built at small cost in the old power-house gives employment to many.

work. One by one during the past few years the fires beneath its boilers have gone out until a year ago last spring when, finally supplanted by a new power house, then the need arose for a building to be used in

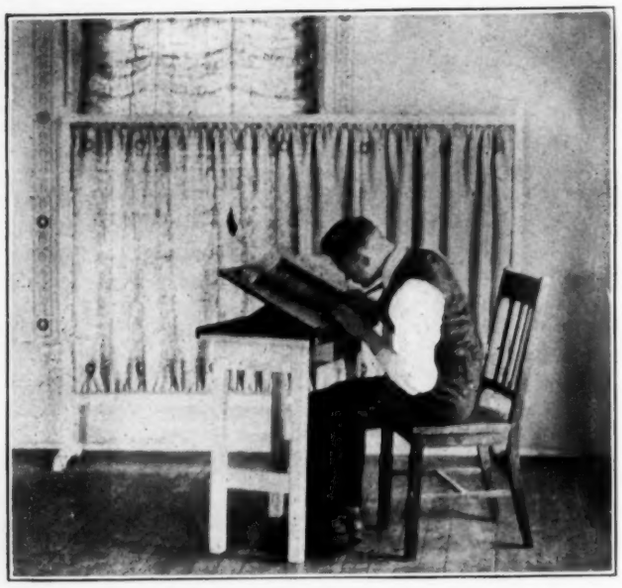


Fig. 6. Woodcarving is among the crafts which mental patients can learn.

connection with the new department, and the forlorn old building was seized upon as the only one available. The old engines and pumps were moved out, and, at an expense not exceeding five hundred dollars, we transformed a three-story wing into a very decent and hygienic place. Then the occupational therapists moved in, wrought a further transformation, and converted the place into a delightful workshop with looms, hand weaving and rug-making on the upper floor; basketry, wood carving, painting, bookbinding, and a library on the second floor, and a manual training and carpenter shop on the first floor. This summer we shall make out of the adjoining old boiler room, a first class gymnasium—about four hundred patients pass through our calisthenic and dancing classes each day—and before winter the old coal bunkers will be turned into a pottery and cement shop.

Good friends—and it is remarkable how many there are of them who are interested in this work—have given gymnasium equipment, playground apparatus, a pottery kiln, a library of five hundred volumes, etc., and now still another proposes to set up a roof garden on the flat roof of the gymnasium, if we can make this stout enough to bear the weight.

Private gifts have, however, merely supplemented the state's generous support. The department has cost in wages and material between four and five thousand dollars the first year, and, during this period, over fourteen hundred working days have also been given by the voluntary aids doing their field work here.

Whether it has paid or not, the reader may judge from this brief recital and from the few cases there is space to describe here. They are given practically as reported in the notes made by their instructors.

The following concerns a ward of women, dementia precox cases, much deteriorated, one-third of them untidy to begin with and all very unpromising cases:

April 19, 1919.—The class is with one exception clean in personal habits. Many of them do not have to be told to wash their teeth. They wear their shoes and keep them laced.

Esther —, no longer has to wear a strong dress. If I wear something a little different she always notices it and speaks of it. When the class started she was not allowed to go on the lawn nor to the gymnasium with us because she would tear her shoes to pieces. Now she knits and crochets and does other handwork very well.

Fannie —, a few days ago cried and refused to work. When asked why she was crying and why she would not work, she said she would not work in "such a dirty dress." Her dress was changed and she worked well all the morning.

Hedwig —, is making an embroidered pillow top and is enjoying it and always telling us how beautiful it is. It took many weeks to get Hedwig into the class and for a long time she would only cut paper.

Lincadia —, has developed much and is brighter in what she says and does. She is making dolls now and dressing them and doing it very nicely. She has also pieced a quilt.

La Hodney —, is not so profane as she used to be, although she still has bad talking days. After she is spoken to she usually stops talking and does her work. When she came into the class the top of her head was also bald where she had kept her hand or arm on it. Now her hands are kept busy and she has a beautiful growth of hair. She, too, is making dolls and dressing them. She knows everything that is said to her and sees everything that goes on. She is the leader in her gymnasium class, helps get work ready mornings; loves to be dressed up.

The following are notes upon cases that have been advanced to work in the occupational center:

Agnes —, dementia precox, at first sat around on the ward and appeared to be listening to hallucinations, though she denied this. She was careless regarding dress, apparently indifferent, and quite childlike in action. When started upon work she had practically no use of her hands. It was weeks before she was able to catch a ball or to follow the simplest movements in the gymnasium. Now she can follow the exercises and take part in simple dances. In handwork she has been very much interested in the making of a bead chain and has done it well; she is very quiet and talked only when asked questions until recently, when she has several times voluntarily asked a question.

John —, dementia precox, at first was careless and indifferent. He frequently took off his clothing; did not talk connectedly and at times not at all. At times he had to be fed and when transferred to CW15 he would not go to the general dining room but would remain on the ward. When he started in the gymnasium class the exercises and games had no interest for him. He first became interested in playing ball when the class was out on the lawn and soon became interested in all the gymnasium work. He started making some very simple toys, but was not able to do any constructive work; displayed interest in painting but continued to have spells of indifference at intervals of about a month apart. These spells gradually became much less frequent and of shorter duration, and he has not had one now for four months. At present he is intensely interested in building a five-room doll-house and does beautiful work. Shows a great deal of originality and initiative. Much neater in personal appearance. Reacts occasionally to voices.

John —, dementia precox, at the time he first entered the occupational class, was very untidy and would not dress himself. For weeks he would not do a thing, simply stared into space. It was necessary to give him individual work in gymnastics. After about three months he would follow a few of the simplest arm movements, and, a little later, he started looking over the work given him to sandpaper. He began whistling a little at his work although would never speak. When transferred to CW10 he became interested in "hooking" a rug and was soon able to follow all the exercises in the gymnasium and enjoy a game of ball. He worked steadily for three months on CW10 in the occupational class, gradually improved, and became more interested in his work. Recently he was transferred to the painters' detail and is working with it at present.

Bolislaw —, dementia precox, when he first entered the occupational class, could only with great difficulty be induced to work. He was very nervous and confused, an-

swered no questions, and did not seem to comprehend what was said to him; constantly prayed, crossed himself, or got up from his work to come over to say, "Forgive me, nurse." He became interested in rake knitting and worked faithfully, but lacked initiative. He works at the occupational center now doing painting, seems interested in his work, and comprehends what is said to him or expected of him. Gets out his own work and cleans up without being told. Physical as well as mental condition is improved. Has at various times asked questions and can carry on an intelligible conversation.

These cases represent more or less successful results. There have been many failures as well. We must not be overly sanguine concerning the effects of occupational therapy. It is not a cure-all; but results like these are well worth while. Even though a small proportion of the patients can actually be returned to home and society, many of those who remain will be fitted to lead more comfortable lives and less time, money, and trouble will be required to care for them, once they are re-established upon a higher plane of thought and conduct.

To accomplish the best results occupational therapy must work hand in hand with constant training in habits of cleanliness and orderliness. Especially is this true upon the more deteriorated wards. Thus far we have been able to establish programs covering the activities of the entire day upon only two wards, one for men and one for women, and here much has been accomplished though not all that we could wish or reasonably hope for if we were able to secure more employees.

A final word should be said for the effect of this new department upon the morale of the entire institution. Already an improvement not entirely confined to the patients has been noted. The humanizing leaven is at work and, if a few manifest dangers can be avoided, in time the entire group of patients, relatives of patients, and employees will be raised to a higher level of hope and helpfulness.

* * * *

THE LIMB-FITTING HOSPITAL AT ROEHAMPTON

Tilting Table Leg and Adams Arm Among the Most Remarkable Mechanical Devices—Thorough Training in Chosen Line Complete Soldier's Restoration to Industrial Efficiency

Captain E. A. Hackett, the representative in France of the Red Cross Institute for Crippled and Disabled Men, recently made a visit to Great Britain and visited the great military limb-fitting hospital for amputation cases at Roehampton, just outside of London.

The hospital has accommodation for a thousand patients and is constantly taxed to its capacity. Assuming some of the general facts regarding the institution to be well known, Captain Hackett writes his observations regarding several specific features.

Tilting Table Leg.—Made in shops on the hospital grounds. This leg has a knee articulation that is practically automatic. The control is by suspension over the shoulders but without need of the patient exercising any direct effort in the management of the limb. "This feature is used on limbs from what are called trunk amputations, I believe, which leave no stump on the lost member. Another feature of this limb is a locking device. I talked with several men who have lost limbs in the war, and are now employed by the Limb Company at the hospital shops, and found that the men fitted with these limbs were doing a full day's work, on their feet practically all the time. The value of this limb is about $110."

Adams Arm.—This is an automatic arm, practically of the same appearance as the usual types. Its special feature is a detachable hand, the removal of which permits the attachment of a wide variety of general and special sockets and holders for tools. The hand is detached at the wrist for light work, and another separation is possible, in the latest type, effected by a conical stiff socket, operated from the side of the arm by a small lever. This second point of separation is just forward of the elbow, and by means of it much shorter leverage can be obtained than through the hand joint; thus the one arm serves for light shop work, and by detaching at point forward of elbow, the wearer is able to adjust much heavier tools and implements without the physical fatigue and risk of breaking his arm, which would be apparent if the heavier tools were attached at the wrist. The cost of this arm is also about $110.

Morale.—The colonel in command of the hospital says that with the present more definite arrangements understood by the men, there is no fault to find with their morale.

Employment.—While the war was going on every effort was directed to get the men fit for some branch of war work, principally munitions, because of the labor conditions, but at the same time the need of education for permanent post-war employment was kept constantly in mind.

Selection and Placement.—The plan followed in the preliminary training given at this hospital is to try to find the class of work the individual can best be fitted for, and to this end instruction has been given in a number of lines. In fact, courses have been open to the men in some lines that they have not taken up in sufficient numbers to justify retaining the course. The colonel says that the men will not touch farm work as a basis for ultimate permanent employment, nor will they take up any line of instruction that savors of personal service.

Left-Hand Copy Book.—There is used here a special copy book for teaching maimed soldiers to write with the left hand. The tutors at the hospital say they have had great success with it, and that with many men it fits in especially well during the long waits necessary to obtain proper fitting of artificial members.

* * * *

Blind Soldiers Keep Posted on the War

Blinded soldiers may keep informed on the war by especially prepared books and maps. Strange to say, the blind themselves prepare these books for their comrades.



Western Newspaper Union Photo Service.
A blind man putting in the battle line on a plate to be printed for the blind.

DEPARTMENT OF DIETETICS

Conducted by LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, Home Economics Building, Cornell University, Ithaca, N. Y.

THE DIETITIAN AS COADJUTOR OF THE PHYSICIAN*

A Hospital Kitchen Without a Trained Dietitian Like a Locomotive Without an Engineer

By HUGH PAYNE GREELEY, M.D., Madison, Wis.

It may be truly said that a hospital kitchen without a dietitian is like a locomotive without the engineer. There is plenty of food in one case and plenty of steam in the other, but the energy in them is wasted unless properly directed. A locomotive with an engineer and a fireman is an efficient instrument of service but they need an organization higher up in order properly to serve the public. In the same way a hospital kitchen plus a dietitian is an efficient instrument of service, but needs in fully as great a degree the intelligent staff of physicians in order to serve patients properly.

In the past, a great many hospitals have been run without dietitians. In this case the physicians or the hospital superintendent did the work of the dietitian, or too often it was left to an untrained cook.

We are glad to be entering this new era in which the physician may have the intelligent cooperation of the trained dietitian. In well-organized hospitals today, the physicians cannot adequately administer this work without help. Dietitians are, or should be, trained to give this help. They bear the same relationship to the physician as the pharmacist does. He fills the prescription. But success requires a great deal more than technical training. The successful pharmacist does not just throw the ingredients together. He prepares his drugs carefully, compounds his prescription accurately, and then dispenses it as tastefully and neatly as it can be done. And he must also exercise economy. The same thing applies a hundredfold to the dietitian. Food represents calories, but should not be served as such. Economy, care in preparation—both as to quality and balance—and in serving are the important things to consider. A dietitian is selling goods in the same way that the pharmacist is, and she must sell service as well.

For a long time the dietitian was accepted rather reluctantly by the hospital board of trustees. The hospital dietitian had rather to force her way along and prove her worth. She has not always made good, so that her employment has often failed to produce the good results that it should. Her failure is not always her fault—for hers is not an independent profession. Coming into the hospital organization under sufferance, having to prove her own value to the hospital, she has seldom been given the power necessary to develop herself and the job as it should be done. Without broad power, her function resolves itself into the work of preparing special diets, which is, to be sure, important and necessary work, but work which is after all restricted to a small number of patients.

There has been further difficulty in the path of the dietitian because of the failure of the hospital staffs of physicians to impress upon the trustees the necessity for conferring broader power on the dietitian. This cooperation between physicians and dietitian is manifestly impossible in all hospitals in which there is no unified medical and surgical staff. Therefore in many small hospitals the proper sphere of action of the dietitian is greatly restricted and hampered. A hospital cannot be efficient in this respect without a unified staff. The dietitian and the medical staff are responsible for the hospital dietary. When we consider that the average daily cost per patient in a modern hospital is from $3.50 to $4.50 a day, and when we realize that fully one-third of this sum is spent for food, we can see that this divided responsibility is a highly important one.

Since the medical staff and the dietitian are responsible for this dietary which represents one-third of all hospital expenses, as long as people are unwilling or unable to pay hotel prices for hospital care, it may be impossible to cater to patients' individual tastes to any degree. The result will be that the vast majority of patients must have served to them a standard diet. In a city of mixed population, one can readily see how difficult it is to serve foods equally suited to separate individual tastes. It would be ideal if the American people could have a standard American diet. After many centuries of education, we will probably work out such a utopian idea, and then the hospital dietitian's path will be simplified. At the present time we have to take the situation as it is, and in order to do the work well, the unified medical staff should meet with the dietitian and plan a few standard diets—just as few as possible. These diets should be based on principles of nutrition, and so far as consistent, on accepted *habits* of eating. It is often of the utmost importance that people's habits should not be suddenly interrupted. When these standard diets are compiled, they should be issued to the medical staff so that they could all cooperate in simplifying the work and avoiding waste.

As I look upon it, the success of the dietitian of any hospital lies in her having broad power; in her being well trained technically, and also as an administrator; in being a person of common sense; and in her having the definite cooperation of a unified medical staff. What makes her a failure today is this lack of direction higher up.

The profession of hospital dietitian should be one of indispensable benefit to modern medicine as well as to modern hospital organization. The food problem of a modern hospital is as difficult and as important as any problem which the hospital trustees have to face. It is one which will require all their business acumen to solve. Too many hospitals in the past have been run on a diametrically opposite plan from that of the successful hotel, whose motto is, "The guest is always right." The attitude of many highly organized hospitals often seems to be, "The patient is always wrong," or "Take what you get and be thankful and cheerful. Don't express an opinion. Patients shouldn't have opinions." The hotel plan proves a financial success; the hospital plan is almost always a financial failure. There are, of course, many other factors which contribute to this failure, but there are also factors which should partially at least counter-

*Paper read before the Annual Conference of the Institution Section of American Home Economics Association, Madison, Wis., June 13, 1919.

balance them. The hospital gets a lot of its most expensive service gratis.

Now it is the business of the dietitian, the medical staff, and the trustees, to work out a successful compromise between the hotel plan which is a success, and the hospital plan which is a failure. We ought to work out something which will at least enable us to come out even and which will be a great improvement upon the imperfect service that exists in many hospitals today. I firmly believe that some patients in hospitals ought to have a menu privilege. This would not necessarily add to the work, and it would add enormously to the attractiveness of a place that has all too few attractions. We are still combating the old idea that the hospital is the place to go when you are going to die, not the place for the best and most comfortable treatment—and what is still more frequently heard and something that cannot always be refuted is, "I would go to the hospital, but you can't get anything fit to eat there."

The problem of the best management of a hospital dietary is still an unsettled one. But one can readily see that the dietitian is the keystone in the arch. She is the go-between between the physician and his patient. She occupies a position that requires more than good training. It rests upon a thorough understanding of food principle, upon a practical knowledge of cooking, upon thoroughgoing common sense and good administrative ability, as well as tact and enthusiasm.

There is another type of dietitian, however, whose importance is not recognized and whose sphere of action is at present limited, and that is the nurse qualified as a dietitian. The time is surely coming, I hope, when people who command $25 to $35 a week, will be even more highly trained than they are today. Nothing will ever justify the present exalted position of the nursing profession or put it on its proper footing, until it adopts the academic standard.

The opportunity for service and the emolument of nurses should immediately demand this step. Every trained nurse should be enough of a dietitian to be able to fill dietary prescriptions at the patient's home as well as the pharmacist does a drug prescription. The future of the nurse as dietitian in the home will be an increasingly great one. Do not think for a moment it is lowering the dignity of the dietitian. It would be raising the profession of nursing.

As with any new profession like that of dietitian, it takes a generation or so to get it properly adjusted in its niche. Practical details can only be worked out through experimentation and finally perfected. All this takes time. Meanwhile, the stress is apt to be put on the theory, and if I were to make a criticism, it would be to say just this—that the training today is overloaded with the theory of metabolism and nutrition, and perhaps too little attention paid to the perfecting of practical details of the hospital dietary. The science of metabolism is also young, and what seem to be facts today are fable tomorrow. The treatment of metabolic disease is only a very small part of medicine, and though an important one, occupies, I feel, an exaggerated place in the training-school today. However, these faults are faults of youth and are not what chiefly hamper your profession today. What we need is the recognition by hospital trustees that the dietitian is not only necessary to the physician, but pays her own salary many times over in the more efficient and economical management of the hospital kitchen.

Physicians are every year more eager to welcome you as indispensable and permanent agents in the organization of modern medicine.

A PRACTICAL FOOD CONVEYOR

A Device Which Keeps Hot Things Hot and Cold Things Cold Satisfactorily Installed at U. S. Army General Hospital No. 1

One of the most difficult problems confronting hospitals and other institutions is the conveyance of food from the kitchen to the various parts of the house. The question is not so much the transporting of food from one point to another as it is the condition of the food when it is served. State or municipal institutions or others occupying several buildings cannot serve "hot things hot and cold things cold," if they have been carried long distances through corridors or open spaces or both unless special attention is given to this service.

The system described below, which was installed at U. S. A. General Hospital No. 1, New York City, by Lieut.



The Eclipse food conveyor designed by Lieut. Frank D. Van Vechten, mess officer at U. S. Army General Hospital No. 1.

Frank D. Van Vechten, gave very good results. Fifty-five wards were served, some of which necessitated traversing a distance of about 3,000 feet. Lieut. Van Vechten, mess officer at the hospital, designed the containers and truck illustrated. He found it kept the food satisfactorily hot, and at the same time simplified the delivery, requiring less time to deliver food to the wards and fewer men to handle it.

The advantages of the device comprise ample capacity, ease of operation, convenience of service, and substantial construction.

The total capacity is 60 quarts. The covered containers provide easy loading space for twelve food boxes, each with a capacity of 5 quarts; they will nest together making the load easy to handle, compact, and permitting little or no loss in heat from the food.

The contents of one container will feed fifty or sixty patients.

Large rubber-tired wheels render its use noiseless. There is complete loading space for nine conveyors, which will feed five hundred patients, by the efforts of one person in the delivery of the food for each respective ward. The four-wheeled truck may be turned on a short

radius and operated with little or no effort. The truck is supplied with two swivel steering wheels that will stand up over long stretches, as well as cross-board corridors. The body of the truck is so arranged that it is easily loaded, constructed to a level such that the containers may be loaded, without slopping of food and liquids.

The truck may be rolled into the ward if desired, or into the ward kitchen, the food served hot, directly, as from a steam table. At the conclusion of the serving the containers and food boxes are cleaned at the ward kitchen, and returned to the source of supply.

The truck is of a construction that will stand hard usage. The body is of angle iron frame with joints which are securely welded. The truck is sanitary throughout, and inviting in appearance. The food containers are made of heavy block tin, with drop handles, and fitted with a drop cover which is dust-proof. The containers are fitted with twelve food boxes, each with a capacity of 5 quarts. There are no corners in the body construction; the containers are double-seamed and are easily cleaned. By the testing of the foods or liquids, it has been proved beyond question that they will retain heat.

There is no insulation required. The accompanying tabular report demonstrates that the conveyors retain heat to a desired temperature for serving.

REPORT OF TEMPERATURE OF FOOD SERVED FROM CONVEYOR.

Truck No.	Food	Start Time	Start Temp.	½ Hour Time	½ Hour Temp.	1 Hour Time	1 Hour Temp.	1½ Hour Time	1½ Hour Temp.
A	"	11:30 AM	75°	12:00 AM	68°	12:30	64°		
B	"	11:35 AM	72°	12:05 AM	67°	12:35	65°		
C	"	11:40 AM	77°	12:10 AM	70°	12:40	61°		

The body of the truck is 52 inches long, 32 inches wide, and 61 inches high from the floor. The wheels are 10 inches in diameter with wire spokes and rubber tires. The total capacity is nine containers, each with food capacity for sixty patients.

* * * *

Conference on Food and Nutrition

A conference on food and nutrition was held at the Johns Hopkins Medical School in conjunction with the meeting of the Federation of American Societies for Experimental Biology, April 25, 1919. There were present at this conference Drs. C. L. Alsberg, H. C. Sherman, Graham Lusk, W. J. Gies, R. G. Hoskins, H. P. Armsby, S. R. Benedict, I. Greenwald, E. B. Meigs, S. C. Prescott, C. F. Langworthy, A. D. Emmet, P. A. Shaffer, A. R. Rose, K. George Falk, V. C. Myers, E. J. Cohn, C. N. Frey, J. F. Brewster, F. H. McCrudden, Andrew Hunter, N. R. Blatherwick, H. A. Mattill, Paul E. Howe, W. A. Perlzweig, W. N. Berg, R. J. Anderson, H. H. Hanson, and Misses Lenna Cooper, Ruth Wheeler, Lulu Graves, and Isabel Bevier and Mrs. Mary Schwartz Rose and Mrs. Norton.

Dr. H. C. Sherman was elected temporary chairman, and Dr. J. R. Murlin temporary secretary. The secretary read a brief address, expressing from the point of view of the Division of Food and Nutrition, Medical Department, U. S. Army, the need for continued organization in the interests of good food, and good nutrition for the public welfare. This was followed by a statement by Dr. C. L. Alsberg regarding the function of the Bureau of Chemistry, Department of Agriculture, and the work which it is authorized to do.

A statement was made by Dr. C. F. Langworthy regarding the functions of the Bureau of Home Economics of the U. S. Department of Agriculture, and the authorizations under which it operates. A motion was passed that the chairman appoint a committee which should have power to consider further what form of organization should be adopted to further the education of the public on matters of food and nutrition. Miss Bevier and Drs. Langworthy, Sherman, McCollum, Mendel, Lusk and Murlin were appointed as a temporary committee to consider further the question of organization. John R. Murlin was appointed secretary and temporary executive officer to conduct further correspondence on the subject.

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NEWS NOTES OF DIETITIANS

Miss Edith Lincoln, one of the dietitians who did such good work at Fort Riley, Kansas, is assistant dietitian at Massachusetts General Hospital, Boston.

Miss Ruth Olsen recently finished student dietitian training at the Minneapolis City Hospital and is now dietitian at the Luther Hospital, La Crosse, Wis.

Miss Florence Wikle, formerly dietitian at Monmouth Memorial Hospital, Long Branch, N. J., is in charge of the dietary department of Lenox Hill Hospital, New York.

Miss Belle Haggerty, who was formerly at San Francisco General Hospital, came East early last winter in order to get in touch with the work being done in the dietary departments of hospitals on the opposite side of the continent. Miss Haggerty spent some time in Philadelphia, then later visited hospitals of New York and Boston, she has now returned to the Pacific Coast to help in equipping the kitchen of the new Alameda County Hospital, which is being built in Oakland. The plans for the service building of this hospital are exceptionally good. The dietary department under Miss Haggerty's supervision promises to be superior to any in the West.

Dispensaries of Social Hygiene for the Prevention of Tuberculosis

E. R. Coni, in the *Semana Medica* of Buenos Aires, discusses the law which provides for the creation of the following institutions: Public dispensaries, dispensaries established by associations, private dispensaries, dispensaries organized by communities and districts, and obligatory dispensaries. The first are the most important as they are supported by the state. Obligatory dispensaries are those which must be established in any community or district if the mortality from tuberculosis exceeds the average mortality from this disease in France. If the community neglects to build the dispensary within specified time, the state authorities select a place and erect the dispensary at the expense of the community.

Hospital Conditions on the East Coast of Sumatra

The work on the plantations of the East coast of Sumatra requires a large amount of foreign help. Coolies from Java, China, and British India are imported for this work. In such a population the danger from infectious diseases is always serious, and in times past the mortality has been very great. Recognizing these conditions, the Dutch government erected thirty-three fine hospitals in the territory, all of which are built on the pavilion plan and are substantial one-story structures.

They are provided with excellent laboratories for the diagnosis of the various tropical diseases. Although in operation only a few years, their influence on general morbidity has been most beneficial. The mortality from tropical and infectious diseases has been reduced to a small fraction of the former death-rate. E. Van de Veide describes this work in the *Ziekenhuis*, Amsterdam.

HEALTH AND MODERN INDUSTRY

Conducted by BARROW B. LYONS
Superintendent Delaware Hospital, Wilmington, Del.

HEALTH PROBLEMS THAT AFFECT EMPLOYER AND EMPLOYEE

Good Health Gives One the Spirit That Creates Efficiency —Physical Examination and Employees' Hospital Secures for the Employee Perfect Health at Minimum Expense to Him

By GEORGE EDWARD PERKINS, M.D., Medical Director R. H. White Co., Boston

The present day has many problems concerning the employer and the employee. One cannot have full measure of success without the other. To make an employee successful, he or she must naturally have the proper training in his or her work, but, after all, unless the health of the employee is kept at 100 per cent, there cannot be proper efficiency. With good health one has the spirit to do things and this creates efficiency.

A machine will produce its maximum only so long as all parts run harmoniously. As is known, if one little cog becomes worn, imperfect and reduced production results. It is so with the human body. Therefore, the health of the employee is of vital importance. The employer extends to the employee the hospital department so that, through the cooperation of the employee, maximum production and efficiency may be obtained.

The employees' hospital is in charge of the medical director; the superintendent of employment and the director of education and welfare cooperate with him to obtain mental and physical fitness in the employees and to maintain them in the condition of highest efficiency.

The hospital is located in a quiet yet accessible part of the store, near the stairs and the passenger and freight elevators.

The hospital is composed of a waiting room, operating room, male ward, female ward, and medical director's office, all having outside windows and plenty of fresh air. A nurse is in charge under the direction of the medical director. Through the medical director there are affiliations with hospitals for the care of operative cases. Eye, ear, nose and throat, and nerve specialists, as well as several surgeons are on call.

Treatments at the employees' hospital are given from 8:30 a. m. to 5:30 p. m. daily. There are special hours for examination and consultation with the medical director.

Lectures on health, hygiene, care of the teeth, care of the eyes, etc., are given from time to time.

The functions of the medical department of the department store are peculiar to itself and far-reaching. We anticipate in the near future the examination of all employees at the time they are hired and at intervals during employment. This eliminates defectives who would be a menace to the store and by this elimination cuts down the turn-over of help. The employee whose defects would allow him or her to be placed in certain positions without detriment to the store production can be placed by the superintendent of employment, after consultation with the medical director.

Eye examinations will correct the defects of vision and will save many errors, besides saving the loss of time from headaches and digestive disturbances.

Examination of the teeth will correct digestive disturbances and overcome objectionable features in the personality of the employee.

Examination of the heart and lungs will make it possible to correct abnormal conditions in the early stages.

Examination for varicose veins, hernia, etc., will give information for the placing of the employee in proper positions and protect the employer against suits for compensation when the employer is not liable.

The physical examination will be of the greatest value to the employee, as perfect health is obtained at a minimum expense to him.

At the present time, in our hospital, accidents and infections are well treated in the shortest possible time after occurrence, and the absence from work is cut to a minimum.

By means of records of absentees we hope that the working conditions will be improved to overcome occupational ailments and that advice may be given regarding rest periods, proper medical care, and vacations. In other words, we hope to improve conditions so that the employee is made and kept fit.

The statistics furnished by records kept in this way show the prevailing ailments and causes of absence. If we know the causes of absence, steps can be taken to remedy them and a healthy, happy, cooperating, efficient body of employees maintained.

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AN INDUSTRIAL CLINIC WITHOUT RECORDS EXCEPT IN ACCIDENT CASES

The Experience of the Pioneers in Health Welfare Work —Greatest Reason for Success of Clinic Is Fact That No Records of Medical Attention Are Kept

By C. E. COYNE, Assistant Executive Secretary, Filene Cooperative Association, Boston

The medical clinic of Wm. Filene's Sons Company was established fifteen years ago at a time when the establishment employed about six hundred people. It was the first step taken by the store towards protecting the health of the employees, and was one of he pioneer clinics established in this section either in mercantile or industrial establishments.

At that time the medical director was in charge of the clinic in the capacity of director of the clinic and visiting nurse.

Since that time the Wm. Filene's Sons Company has grown into a total pay-roll of 2,700 employees and the clinic has developed accordingly, with three trained nurses now employed and a well known practicing physician and surgeon attending cases in the store and in consultation at the clinic two hours per week. He is also in charge of the administration and organization of the clinic.

An excellent example of the most efficient work done by the clinic is shown by the report of the influenza epidemic which raged in Boston for four months from September, 1918, through January, 1919. In that time, of the total number of employees, only six deaths were recorded and over 350 employees were treated per day. In all justice to the dreaded disease, all cases cared for in the

clinic were not influenza cases, but in a number of instances the person was afraid of the symptoms and all cases were given careful individual attention. Whenever the temperature was found to be a fraction above normal, the employee was sent home.

The follow-up work of the clinic is particularly valuable. The visiting nurse calls upon the employees who are ill to ascertain their condition. In no case does she interfere with the family physician who may be in attendance. However, if after consultation it is found that a specialist is necessary, arrangements are made for his services, and if it is found that there is no doctor in attendance and one is needed such arrangements are also made. Through conversation with the members of the family or through observation it may be found that the home conditions warrant a continuance of payment of salary or wages. If so it is left to the discretion of the nurse to secure same as long as it is necessary.

It is the policy of the nurses in the clinic to advise all employees who visit them or whom they visit to be insured, an activity which the Filene Cooperative Association, the employees' organization, handles themselves. The purpose of such advice is to secure insurance for all employees in order that they may receive its benefit after one week's illness. This arrangement does not place a premium upon employees being ill, and at the same time the clinic cooperates in the matter of insurance.

Probably the greatest factor in the success of the clinic has been the fact that no records are kept of medical attention except in the case of accidents, when the operation of the workmen's compensation law compels such records to be kept. The same consideration is given to employees who visit the clinic that a doctor gives to his patient, namely, that the treatment is absolutely confidential and a matter between the nurse and patient, and one in which neither the management nor the other employees should have any concern.

The clinic handles 150 to 200 cases per day, and in its attention to these cases it is a great preventive measure against illness and absence from work. Employees are urged to visit the clinic for the slightest reason, in order that colds, etc., may be remedied before more serious developments necessitate their confinement at home and extra medical attention. For this one reason alone, the clinic has a most important place in the daily work of our employees. To give some idea as to the number of accidents, which of course include a number of minor cuts and bruises, the clinic treated 1,450 employees in 1918, and 350 customers.

The attending physician and surgeon at the clinic has definite office hours of two hours per week, and in cases where medical attention is needed during the time that he is not in the store, a list of doctors who are available is kept at the clinic. A list of specialists is also kept and arrangements are made with them for special rates for Filene employees. The reason for not having a physician in constant attendance in the clinic is that the daily number of cases are of a nature that does not require a physician but can be handled by the nurses. Then, too, it would not take up all of his time and to have the man whom the firm would want, with a particularly high standing in the medical world, would be neither practical or economical.

A dental clinic is in a formative state and no doubt will be established and organized in a short time. The plan and method of administration and organization is simply in the making. It is safe to say that the dental clinic will be as efficient as our medical clinic.

In conclusion, the medical clinic has proven its value and efficiency in protecting the health of the employees of the Wm. Filene's Sons Company and its reputable standing merits the commendation of mercantile and industrial establishments whose representatives have visited and inspected it.

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WHAT THE WORKING MAN THINKS OF HEALTH WELFARE

James H. Maurer, President of the Pennsylvania Federation of Labor Points Out Some Dangers—The First Step in the Conservation of Life

The attitude which the workingman takes toward Health Welfare Work is almost as important as the attitude of his employer, and at times becomes more important. Welfare plans have been wrecked many times by the unsympathetic action of employees.

In order to get the point of view of the man in the mills toward the work which is now being planned at Washington on a magnificent scale, James H. Maurer, president of the Pennsylvania Federation of Labor, which is affiliated with the American Federation of Labor, was asked to tell how the worker felt toward free medical and surgical examination and treatment.

Few labor leaders are respected and loved by their follow workmen more than Mr. Maurer. It is fair to say that his opinion represents that of hundreds of thousands of workingmen in Pennsylvania. The editor of this department heartily disagrees with some of Mr. Maurer's conclusions, but presents his views as they were given. His letter follows:

To the Editor of the Department of Industrial Welfare:

"In reply to your inquiry as to 'what the workingman thinks of free medical and surgical examination and treatment inaugurated by certain industrial concerns,' will say that the so-called free medical and surgical treatment is in its final analysis, not free, because the expense involved is not extracted from profits but added to the product which society must pay and the workers being, in the great majority as consumers, indirectly pay for this so-called free service.

"That the plan would, however, be a great saving to the worker is self-evident, if it was not abused, but, when the company physician causes a worker to lose two weeks' working time without compensation because of a slight injury, on the plea that to remain at work might cause infection, then the worker is paying a mighty big price for the free (?) medical or surgical service. This outrage was inflicted upon many workers throughout Pennsylvania after the Workmen's Compensation Act became operative and before the demand for unskilled labor, due to our entrance into the war.

"During the year 1917, two hundred and thirty-two thousand workers were injured in Pennsylvania's industries; for different reasons many never got their old jobs back. Compulsory physical examination, to many of these people, means discrimination. The same is true of those suffering from occupational disease. If the aim of compulsory physical examinations was higher efficiency, and the placing of cripples or those suffering from chronic ailments in jobs for which they are best fitted, no one could seriously object unless the employers felt that the physical defects of the unfortunates that they employed gave them license for extra exploitation.

Concerns that demand physical examinations of those they employ seldom have in mind the placing of defectives in positions for which they are best adapted. Their aim is to get workers physically sound who can stand the speeding-up pace that modern industry demands. When broken in health, crippled or worn out, they fail to pass the physical examination and are cast upon the human scrap-heap, the present war period excepted. There are, however, shining exceptions to the common rule. I know of concerns that employ real physicians whose sole purpose in examining the employees at regular periods is to keep them in the best possible physical condition and this, to be sure, is to be commended.

"The workers are quite conscious of the fact that their earning power is, in a very great measure, dependent upon the physical condition of their bodies and are as

eager as the employers that this earning power be not impaired. But compulsory physical examinations by the employers' doctors and the plant stuck full of safety-first signs does not appeal to the worker who sees all around him unguarded machinery, pitfalls, death-traps and general all-around insanitary working conditions and whose income may compel him to live in some disease-breeding shack or tenement.

"The first great step in the conservation of human life and energy is not free (?) medical or surgical treatment, but to learn the mystery of our own bodies, tear aside the cloak of sham and modesty, learn how to live clean lives, quit driving the workers to the point of exhaustion, eliminate the profiteer, stop the exploitation of labor and there will be little need for medical service.

JAMES H. MAURER, President.
Pennsylvania Federation of Labor, Harrisburg, Pa.

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A Practical Answer to Why it Pays to Protect the Health of the Worker

The extent to which level-headed practical business men consider industrial health work a paying proposition is pointedly illustrated in a letter received by the editor of the Department of Health and Modern Industry, from Mr. L. A. Wheeler, manager of the New Departure Manufacturing Company, Bristol, Conn.:

"Our welfare work consists in helping all families where the working employee is sick or during the sickness of any of the family. I will tell you of one incident of many. This is a typical sample of our welfare work.

"A man who was laid up for four weeks (a foreman of one of our important departments), and the local doctor did not seem to know what to do. The doctor was treating him for rheumatism, but the case got so bad that I had him sent to the Hartford Hospital, where he was operated on by Dr. Sweet, who is one of the best surgeons in this part of the country. It was a case of diseased femur. I saw the doctor after the operation, and he said if the case had gone another month the man's leg would have had to be taken off.

"This is not a compensation case, and we have paid all expenses and are assisting the family financially, and will continue to do so until the man gets back to work, which will be another month at least. When he goes back he is to reimburse us in small amounts per week for money we have spent. Our idea is not philanthropy, but to get the man back to work as soon as possible.

"It is merely a gamble of one hundred dollars or so against this man's life. We feel that if he does get well and back to work he will be not only a good employee, but a good booster for this company.

"This is one of many such cases which we have handled in the last year. We do not advertise our welfare work very extensively, but when a man or family is in need and is worthy, we stand behind him. I believe that this kind of work is making the men more contented and happy."

"Typhus Train" Aids Russian Refugees

A specially equipped "typhus train" financed by funds supplied by the Interallied Sanitary Commission and managed by the Red Cross, has traveled from Vladivostok to the Ural Mountains, its staff of doctors and nurses ministering to persons afflicted with the malady and instructing the people in preventive measures. At the present time this train is operating among the soldiers of the Kolchak government on the Perm front. Many carloads of drugs and medical supplies have been provided for the men of the Russian army. A special Red Cross mission which recently made a survey of the situation in western Siberia found that many of the hospitals had been stripped of drugs, instruments and surgical dressings. The Red Cross is equipping these institutions. In all, about forty tons of drugs have been shipped from America since last September.

About 1,500 refugees remain in and around Vladivostok and these have been concentrated in barracks a few miles outside of the city.

HOSPITAL, MEDICAL AND SPECIAL MEETINGS

CATHOLIC HOSPITAL ASSOCIATION OF U. S. AND CANADA

Fine Spirit of Loyalty and Progress Displayed at the Fourth Annual Convention

The Fourth Annual Convention of the Catholic Hospital Association of the United States and Canada was held June 25, 26 and 27, 1919, in the assembly hall of St. Francis Xavier Academy, Chicago.

After mass said by Most Reverend Sebastian G. Messmer, Archbishop of Milwaukee and honorary president of the association, the meeting was opened by the honorary president's address and the address of the president, Rev. Charles B. Moulinier, S.J.

Progress in Hospital Standardization

"It is only the standardized mind," Father Moulinier said, "that can possibly attempt to standardize other minds, and similarly it is only the standardized institutions that can attempt to standardize other institutions." The medical and nursing professions are not yet standardized. There are only a few men and institutions that are. There is just one association of medical men and just one official hospital association that are making earnest efforts to standardize themselves. Dr. John G. Bowman is the only man who has had the vision to attempt to standardize his own mind.

The plan of standardization offered by the American College of Surgeons is simple, workable and logical. It can be put into operation in any place and under all circumstances, but there must first be earnestness and there must be organization. It calls for records, brief, correct, scientific and conscientious; it demands adequate laboratory service which must not depend upon the special fees which a patient can pay. It demands organization in the medical staff of the hospital.

The superintendents and doctors must know the latest and best things that are being done in hospitals. This knowledge is to be obtained through training, through visiting other institutions, through attending hospital associations, through consultation, through weekly and monthly meetings of doctors and sisters, and through reading of medical and hospital journals. In this connection, Father Moulinier announced, the project of a Catholic hospital bulletin to contain the proceedings of the Catholic Hospital Association and other news and information of interest and importance to Catholic hospitals.

In connection with the organization of the hospital, Father Moulinier emphasized the necessity for prompt, kindly intelligent telephone service, for prompt and careful attention to letters and questionnaires and for the posting of bulletins in the hospitals giving information to the staff and employees.

After Father Moulinier's address, the association voted to increase the annual dues for personal membership from

$2 to $5 to provide the means for issuing the bulletin and doing the other work of extension planned by the association. The fees for institution membership are graduated from $5 for institutions under 50 beds to $30 for institutions above 250-beds capacity.

Principles and Facts of Standardization

Mr. John G. Bowman, director of the American College of Surgeons, said that in addition to staff organization, case records, and clinical laboratories, there are many phases of good hospital work that should come into a complete plan of standardization. Such matters as research work, the training of nurses, the training of interns, the out-patient department, etc., are of course important. But let us not try to do too many things at one time. If we can get together throughout all of the hospitals on a definite plan of organization, of keeping case records, and of adequate laboratory service, we shall do much to usher in a new era in the practice of medicine. Many of our other problems will in this process take care of themselves.

Hospital standardization is not a set of tricks or of rules which will bring about the changes we all desire. It is a set of principles which must find their springs of action first in your hearts. These principles you must believe are right if they are to succeed. And then, if you believe they are right, it is your duty to work, to fight, to die if need be, to put the principles into action in your hospital.

There is no group of hospitals on the continent or in the world that has more idealism and more of the determination to attain true standardization than those that compose the Catholic Hospital Association.

How We Standardized Our Hospital

Dr. F. A. Stratton, St. Joseph's Hospital, Milwaukee, said that prior to the introduction of standardization in St. Joseph's Hospital there was no system and no means of determining the character of the work done. The staff existed on paper and was without function. Once a year it met and discussed the war. It had no authority and offered no suggestions for the betterment of the institution. The records kept were altogether inadequate. A patient could be brought in and operated on without anyone being able to determine what the matter was, what had been done, and what the result was. Dr. Stratton said he never realized what this condition was until he had occasion to refer to his own records. The patient escaped with his life, and that was all that could be established by the record. The laboratory was neglected and autopsies were faulty. There was an impression that incompetent men practiced there; but no one wanted to take the initiative in eliminating them. The credit for the change is due to Mr. Bowman, Father Moulinier, and Dr. McGrath, "who," said Dr. Stratton, "put a little of the fear of God into our hearts. Most of us need to have a club held over our heads; believe me, this club was very helpfully used."

When it was decided to organize a staff the question arose, who should be members. It was decided to admit only specialists. Punctilious attendance at staff meetings was insisted upon; after three absences a man automatically ceases to be a member. Meetings are held once a month. There is a business committee of three who represent the staff in its dealings with the administration. The pledge of the American College of Surgeons is required of those who practice in the hospital. Records, of course, are insisted on. The hospital had no interns and it was necessary to induce the staff men to make records, and to make them like to do it. Now a history and tentative diagnosis must accompany the patient to the operating room, except in cases of emergency. Otherwise operation is refused. This has resulted in no loss of patients to the hospital. On the contrary, it has had to turn patients away on account of lack of beds.

Medical Practice in Hospitals

Dr. Louis D. Moorehead, Mercy Hospital, Chicago, opening the discussion on this subject gave plans of organization by which hospital staffs might be organized.

The Training School from the Doctor's Point of View

Dr. E. L. Tuohy, St. Mary's Hospital, Duluth, Minn., said that if he were to attempt to detail the good things in the sisters' hospital it would take up all of his time. Not every hospital, however, is thoroughly coordinated. Often a medical man is inclined to teach the nurse as if she were an embryo doctor. He would do better merely to emphasize the medical aspects of nursing. Again the nurses are taught on the hypothesis that in emergencies they may be called upon to do extraordinary things. This seldom happens. It is not worth while to attempt to drive into the poor nurses' heads everything that the doctor has learned through education and experience. The nurse should bring to the hospital a desire to enter a profession and not a trade, health and strength, and basic psychological development. The hospital on its side should offer material comprising different types of sicknesses, classification of patients according to disease and treatment, and suitable quarters and provision for recreation for the nurses. There should be a lay superintendent for lay nurses, and also a lay nurse on each floor



Delegates of the Catholic Hospital Association assembled on the beautiful lawn of St. Xavier Academy, Chicago, where

as assistant to the sister in charge. The sisters should not be overwhelmed with detail, for they have special gifts in making the patients feel at home, which they should have opportunity to exercise. Nurses should rotate on different duties and have an opportunity to learn something of the business management of the institution. Effort should be made to secure proper material for the training school through careful examination of applicants. Much money is wasted trying to train unsuitable candidates. Probationers unsuited for finishing the course should be directed into lines of activity for which they are better fitted.

The Formation of State Conferences

The Rev. M. F. Griffin of St. Columba's Church, Youngstown, Ohio, president of the Ohio State Hospital Association, presented a strong paper on the value, importance, and necessity of strengthening the Catholic Hospital Association in numbers and activity by the formation of State Conferences and Sisters' Hospitals, at the end of which he moved, and the convention passed a motion that state and provincial conferences be formed. Father Griffin was appointed director of this work.

A Phase of Medical Social Service

Miss Ann Doyle of Washington, D. C., representing the Surgeon-General, of the U. S. Army, spoke on the prevention of venereal disease in the United States. Of the first million men called out in the draft, she said 2.9 per cent had venereal disease. In the second million there was 4.5 per cent. The latter percentage did not represent a worse type but better examinations. As a result of the facts thus brought out, twenty-eight clinics were founded for free treatment of venereal disease in various localities, and thirty thousand civilians were treated. The Chamberlain-Kahn bill appropriates $1,200,000 and authorizes the founding of 260 clinics. A most important phase of this work is social service. Mere dosage with arsphenamin, etc., is absolutely ineffective unless followed up with social work. This is done by registered, graduate nurses with social training. While there is much good social service work done in hospitals there is little done with venereal diseases, especially preventive work.

Miss Doyle said that she had received her first inspiration and instruction on the need for such work from a sister of charity. Her first instruction in the origin of life came from another sister of charity. Who is better able than sisters and priests, Miss Doyle asked, to teach purity of life?

A Boys' Industrial Home

Father Flanigan of Omaha told something of the work of the boys' home with which he is connected, and its work in caring for boys who would otherwise be derelict. Part of the expenses of the home are made by the sale of soap powders and laundry products manufactured by the boys. Father Flanigan asked for the patronage of the Catholic institutions.

Report of Conferences

On June 26 conferences were held of Mothers Superior and superintendents of hospitals, supervisors and teachers of nurses' training schools, supervisors of records, laboratory technicians, operating room nurses, dietitians, anesthetists, and social service workers, respectively, and brief reports of the results were made to the convention. Among the points brought out were the following:

In regard to records, the right person to elicit the history from the patient is the doctor, but the intern should be with him at the time, for the sake of his education. Standard history blanks and records should be used, and the supervisor of records should refuse under all circumstances to accept an oral report.

One of the most important questions in regard to laboratory work is that of charges. It was decided that the best means is a flat charge proportionate to the price of the patient's room added to the bill. Laboratory work is in many cases necessary for a correct diagnosis, and, although it is difficult in some cases to get doctors to have it done, it is becoming more customary. If the laboratory is given a chance, it will always make itself felt. Port-mortems also should be encouraged.

The consensus was that the supervisor or teacher of a nurses' training school should preferably be a nun, and that nursing standards at the present time should be raised rather than lowered.

The extreme value of social service work was emphasized, and it was stated that medical service in the hospitals is never complete unless social service follows.

Answers to Questionnaires

An interesting and valuable feature of this session was the answers to questions handed in by the members of the association, although the committees appointed to formulate replies had a difficult task, owing to the large number of questions and the fact that some of them were so extensive as to call for a lengthy and exhaustive treatment, and hence could scarcely be answered in the few minutes allowed for replies. A white uniform dress with white shoes was approved for sisters in the operating room.



the fourth annual convention was held June 25, 26 and 27. Many orders from the United States and Canada were represented.

The reply to a question in regard to the success of female historians and record keepers was that female historians were very unsatisfactory, because male patients will not give them detailed histories. Female record keepers and checkers of records have been successful.

The reply to a question as to the osteopath, the attitude of the hospital toward him and his privileges in the hospital, was that the osteopath has no privileges.

Election of Officers

As recorded in the July issue of THE MODERN HOSPITAL, the Most Reverend Sebastian G. Messmer, Archbishop of Milwaukee, Reverend Charles B. Moulinier, Regent of the Marquette School of Medicine, Milwaukee, and Dr. Bernard Francis McGrath, of Milwaukee, were reelected honorary president, president, and secretary, respectively. Rev. M. P. Bourke, Ann Arbor, Mich., was elected vice-president. Vice-presidents are to be named from each order represented in the membership of the association.

The members of the Executive Board are as follows: Dr. Joseph Byrne, New York; Dr. L. D. Moorehead, Chicago; Mr. Michael Zimmer, Cook County Hospital, Chicago; Sister M. Veronica, Chicago, Ill.; Sister Mary Picher, Montreal General Hospital, Montreal; Sister Bernadine, St. Joseph's Hospital, St. Paul, Minn. There is in addition an advisory committee consisting of bishops and archbishops.

Outstanding Impressions

While it is impossible in the compass of this summary report to do thorough justice either to the many valuable papers presented or to the splendid spirit of the convention as a whole, a few impressions must be recorded, even though briefly and inadequately. One is that the Catholic Hospital Association very emphatically affirms its adherence to the doctrine which it holds as a Catholic association, while standing for progress as a hospital association. Another is the increase in vital interest shown by the participation in the proceedings of the sisters and staff members not on the program. It is quite evident that the membership of the Catholic Hospital Association is awake to the demands of the highest ideals and is thoroughly in earnest in its attempt to realize those ideals.

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NATIONAL SOCIETY FOR THE PROMOTION OF OCCUPATIONAL THERAPY

Third Annual Conference to Be Held in Chicago, September 8 to 11, with Headquarters at the Henry Favill School of Occupations

The third annual meeting of the National Society for the Promotion of Occupational Therapy will open its sessions at Bowen Hall, Hull House, Chicago, on Monday afternoon, September 8. This will be an open meeting and a second open session will be held Monday evening. All meetings will be held in Bowen Hall, Hull House.

Tuesday, September 9, a morning session will be held at Bowen Hall and the entire afternoon will be given over to a visit to Chicago State Hospital, where occupational and recreational work will be inspected. (This work is described in an article by Dr. Charles F. Read, superintendent of the hospital, on page 128, this issue.) An address on psychiatric reeducational work will be given on Tuesday evening by a prominent psychiatrist. A banquet at one of the leading hotels is scheduled for the evening.

Wednesday, September 10, the entire day will be spent in Milwaukee, upon invitation of Miss Elizabeth G. Upham advisor in occupational therapy and her co-workers at Milwaukee-Downer College.

Thursday, 11, the closing sessions will be held, morning and afternoon, and visits paid to the Presbyterian Hospital, Cook County Hospital, and if possible, to Fort Sheridan.

Many distinguished scientists as well as occupational therapists have accepted invitations to participate in the various sessions of the conference, among them: G. Canby Robinson, M.D., dean of the Washington University Medical School, St. Louis; Captain Bott, Hart House, University of Toronto; Dr. Norman Burnette, Department of Soldiers' Civil Reestablishment, Canada; Douglas C. McMurtrie, Director Red Cross Institute for Crippled and Disabled Men, New York City; Herbert Hall, Devereux Mansions, Marblehead, Mass.; Frankford Williams, M.D., National Committee for Mental Hygiene, New York City.

The officers of the society are: president, Dr. William Rush Dunton, professor of psychiatry, Johns Hopkins Medical School, Baltimore, and assistant superintendent Shepherd and Enoch Pratt Hospital, Towson, Md.; vice-president, Mrs. Eleanor Clarke Slagle, superintendent of occupational therapy, Illinois Department of Public Welfare, and director of the Henry B. Favill School of Occupations; secretary, Mr. Louis J. Haas, director of occupational therapy for men, Bloomingdale Hospital, White Plains, N Y.; treasurer, Miss Marian Taber, State Charities Aid Association, New York City.

The headquarters of the society during the conference will be at the Henry Favill School of Occupations, 825 W. Polk street, Hull House block.

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AMERICAN DIETETIC ASSOCIATION

Program of the Forthcoming Meeting at Cincinnati—Practical Value and Scope of Papers

The following program of the meeting of the American Dietetic Association to be held at the Hotel Gibson, Cincinnati, September 8 to 12, is practically complete, with the exception of Tuesday forenoon, September 9. A few points of practical value regarding equipment, service, etc., will be discussed in addition to the subjects specifically mentioned, and there may be some changes in arrangement; but the members of the committee feel reasonably sure that the papers scheduled will be presented.

Practically, all phases of dietetics are represented—administration, teaching, social welfare, and dietotherapy.

There will also be round table discussions, affording an opportunity for the superintendent and the dietitian to present problems of a definite nature and help each other in their solution.

Further information may be obtained by addressing the president, Miss Lulu Graves, whose present address is 58 East Washington street, Chicago, or the secretary, Miss E. M. Geraghty, New Haven Hospital, New Haven, Conn.

Program

MONDAY, SEPTEMBER 8

AFTERNOON, 3 P. M.

Registration.

EVENING, 8 P. M.

Informal gathering, music, inspection of exhibits (with American Hospital Association).

TUESDAY, SEPTEMBER 9

MORNING, 10 A. M.

General Session.

AFTERNOON, 2 P. M.

Subject: Courses of Instruction for the Training of Dietitians, Katharine Fisher, Teachers College, New York City.
Discussion, Lenna Frances Cooper, Battle Creek Sanitarium.
Subject: Training of Pupil Dietitians, Violet Ryley, University of Toronto.
Discussion, E. M. Geraghty, New Haven Hospital.

Subject: State Board (Nursing) Requirements in Dietetics, Helen Wells, Drexel Institute.

EVENING, 8 P. M.

Reception and inspection of exhibits (with American Hospital Association).

WEDNESDAY, SEPTEMBER 10

MORNING, 9 A. M.

Section on Teaching, Katharine Fisher, chairman.
Subject: Standardization of Curriculums for Nurses' Training Schools, Miss Ruth Shelow, University of Cincinnati, formerly instructor Army School of Nursing.
Discussion—
Subject: Relation of the Dietitian to the Hospital Staff, Annie W. Goodrich, formerly dean, Army School of Nursing.
Section on Social Welfare Dietitians, Blanche Joseph, chairman.
Subject: Training of Social Service Dietitians, Emma Winslow, Charity Organization Society, New York City.
Subject: Social Service Dietetics, Mary Shapiro, director of Bureau of Home Economics and Dieteties, New York City.

AFTERNOON, 2 P. M.

Section on Administration, Emma Smedley, chairman.
Subject: Dietitian Service Abroad, Bertha N. Baldwin, with American Red Cross, France.
Subject: Problems in the Administration of Government Dormitories, Miss Olive Davis, assistant manager, Government Hotel, Washington, D. C.
Section on Dietotherapy, Minnie A. Phillips, chairman.
Subject: Dietotherapy, Dr. Baumann, University of Iowa.
Discussion.

EVENING, 8 P. M.

Subject: Some Feeding Problems "Over There," Mabel C. Little, with Y. W. C. A. and Y. M. C. A., France.
Subject: Hospital Cafeterias, Eleanor Wells, Teachers College, New York City.
Discussion, Sate Harris, Massachusetts General Hospital.
Subject: Cafeteria Management, Blanche Geary, National Y. W. C. A., New York City.
Discussion.
Subject: College Feeding Problems, Emma Baker, Teachers College, New York City.
Discussion, Elsie Leonard, University of Wisconsin.

THURSDAY, SEPTEMBER 11

MORNING, 9 A. M.

Chairman, Bertha M. Hyde, dietitian Cincinnati General Hospital. Round table of discussion led by Miss Lulu Graves.
Topic: Institutional Problems.

12:30—1:30 P. M.

Buffet luncheon at Cincinnati Medical College, with the American Hospital Association.

AFTERNOON, 2 P. M.—3 P. M.

Chairman, Lulu Graves, president American Dietetic Association, Cornell University, Ithaca, N. Y.
Address: The Relation of the Physician and Dietitian, Elizabeth Campbell.
Address: Dietetics from a Physician's Standpoint, Roger S. Morris, M.D.

3 P. M.

Open House at the Woman's Building, University of Cincinnati.

EVENING, 7:30 P. M.

Business Session, 8:00 p. m.

Subject: Work of the Red Cross Chapter Committees on Nursing Activities, Clara D. Noyes, acting director, Department of Nursing, American Red Cross, Washington, D. C.
Subject: The Dietitian in the Public Health Service, Wm. H. Walsh, Hospital Division, Public Health Service.
Subject: The Organization of the Dietary Department of a Military Hospital, Winifred Short.
Moving Picture Film, "Food Supervision for the Army," Lieut.-Col. J. R. Murlin, University of Rochester (former chief of the Division of Food and Nutrition).

FRIDAY, SEPTEMBER 12

MORNING, 10 A. M.

Subject: The Dietitian in the Hospital Dispensary, Bertha Wood, Food Clinic, Boston Dispensary.
Subject: What We Have Learned in Dietetics from the Army, Lieut.-Col. J. R. Murlin, M.C.
Subject: Hospital Food Waste, Ernest E. Irons, Lieut.-Col., M.C., formerly commandant, Base Hospital, Camp Custer.

AFTERNOON, 2 P. M.

Subject: Diet in Disease, Mary Swartz Rose, Teachers College, New York City.
Report of the meeting of the American Home Economics Association, Ruth Wheeler, Goucher College.
Report of the Committee on the Standardization of Curriculums for the Training of Dietitians.
Report of the Committee on Nomenclature.
Report of the Committee on the Standardization of the Work of Dietitians.
Miscellaneous Business.

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THE FIRST ANNUAL MEETING OF THE NEW JERSEY HOSPITAL ASSOCIATION

Home State of President Falls in Line With a New Hospital Association—Auspicious Initial Meeting in the Board of Trade Rooms, Newark

Some thirty of the progressive hospital superintendents of New Jersey were in attendance at the first annual meeting of the New Jersey Hospital Association held at Newark, June 26. The board of trade, recognizing the importance of such an organization for the welfare of the city and state, extended the courtesy of the use of their rooms for the meeting. The temporary chairman was Mr. Charles E. Talbot, superintendent of the Newark City Hospital.

Officers elected for the year 1919-1920 are: president, Dr. George B. Landers, Morristown Memorial Hospital; first vice-president, Rev. Thomas A. Hyde, Christ Hospital, Jersey City; second vice-president, David Schwab, Barnett Memorial Hospital, Paterson; third vice-president, Miss Louise Pugh, R.N., Middlesex General Hospital, New Brunswick; secretary-treasurer, John C. Vidt, Newark City Hospital. The executive committee consists of Miss Eugenia A. Ayers, Elizabeth General Hospital; John M. Smith, Muhlenberg Hospital, Plainfield; Joseph Karrakis, Beth Israel Hospital, Newark. The next meeting of the association will be held at Elizabeth on Thursday, October 9, 1919.

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CONFERENCE OF INSTITUTIONAL MANAGERS

Institution Section of the Home Economics Association Holds Interesting Meeting

A meeting of the institution section of the Home Economics Association was held in Madison, Wis., June 9-13.

Many phases of lunch-room management in various kinds of institutions were represented at this meeting, and some definite practical things accomplished.

The suggestive course of study will be discussed in the meetings as mentioned and a report given later.

At the opening meeting on Monday, President Birge drew attention to the change in training and ideals of women in the past few years. The former training was haphazard and imperfect; the present training, perfect and scientific.

Miss Abbie Marlatt, head of Home Economics Department, University of Wisconsin, considers institutional management a graduate study. Only fundamentals are suitable for undergraduates, such as science, economics, labor problems, psychology. All life is institutional except that of the child.

On Tuesday, Mr. Walter H. Gregory, Hotel La Salle, Chicago, gave an important paper on "What the Hotel World Wants." The hotel problem, he said, is to provide entertainment for the transient—a civic, political, and social center for him. The highest grade of service ideal takes 75 to 85 individuals to serve each individual hotel guest. To give this service cooperation in the full is paramount. The manager is responsible for the financial success, organization, and service. He must be an executive, quick judge of men, quick thinker, quick to act and coordinate, up-to-date and alive to changing conditions. An ideal is desire to serve to the end of satisfaction. There is no limit to the possibilities of women employment "if" they can measure up to the requirements. These are a matter of personality and responsibility rather than of training. The successful manager's personality must be cordial, but impersonal—"able to greet a fellow as a friend and let it go at that." Women fail in responsibility; they are often lacking in sense of loyalty to the "job" duty, etc., either through an exaggerated sense of fun, or ill health, or claims of family or friends.

This paper was very thoroughly discussed—the consensus did not agree with speaker, thereby, perhaps, proving this point of the almost impossibility of woman's temperament to take an impersonal view of a situation.

Mrs. Lois P. Hughes, of the Hotel McAlpin, discussed

"Opportunities for Women in the Hotel World." Hotel world, she said, is fast becoming a huge industrial organization of its own. There are openings for women in many lines, as: (1) Housekeeper in charge of labor, linens, soaps, cleaning, and interior decoration; (2) floor clerk in charge of mail messengers, keys, guests' comfort, and lost and found department; (3) bookkeeper and cashier, or comptroller of food sales accounts; (4) workers in every department of the kitchens; (5) sanitation expert; (6) hostesses in charge of woman's floor and as purchasing aid; (7) officers and helpers in charge of special dining rooms; (8) publicity department in connection with records, advertisements, party forms, etc.

The increase in the employment of women in hotel service has been from 25 to 35 per cent and women have proved to be 60 per cent efficient. Women need training in courage, cooperation, and courtesy. They are more careful, ingenious and economical than men. Women need to acquire the right attitude of mind; to forget about time to come and about her girlhood home, to educate her family *not* to demand her services, but to consider her business as important as that of the business of the men of the family. Women need training in the (1) development of the impersonal attitude, (2) development of responsibility, (3) administrative work, and (4) practical problems—through apprenticeship. Mrs. Hughes and Mr. Gregory agreed to this need, but hotel work is so busy there is little time for apprenticeship.

Miss Lenna Cooper, supervising dietitian, United States Army, Washington, D. C., was chairman of the Wednesday meeting, devoted to institutional administration courses. Miss Cooper has come to realize the need of standardizing training for dietitians. As army hospitals decrease, public health service will increase. The conference recommended a minimum two-year course, to be considered and discussed at the Home Economics meeting, Blue Ridge, N. C., and at the meeting of American Dietetic Association, Cincinnati, and then to be recommended to the governor. A committee consisting of Miss Lena Casper, Battle Creek, Mich., Miss Abbie Marlatt, Home Economics, Madison, Wis., Miss Chloe Clark, University of Washington, Seattle, Wash., Miss Fee, Pratt Institute, Miss Treen, school lunch system, Boston, Miss Leonard, director of commons, Madison, Wis., and Miss Sanford, Cornell University, was appointed to work out such a course.

Miss D. B. Treen, chairman of the Thursday session on school lunches, gave the history of the Boston system and described the system, which comprises a central kitchen, sending food to nineteen centers. Her conclusions are that the central kitchen will never serve high school pupils the desired variety, but that it has certain advantages, including check of food, materials all in one place, one set of experts in one place, and skilled labor for all at a lower cost. Under normal conditions, she says, the lunch will pay for itself. The movable equipment is paid for by organization. The room and fixed equipment are furnished by school system.

In Philadelphia, the system is under central supervision and authority—under the school board; the city buyer does not buy lunch supplies. There is a dietitian in charge of every school, who trains untrained women in actual charge of cooking in each school. Penny lunches in grade schools are not self-supporting.

In Chicago, the penny lunch board controls and pays the help; domestic science teachers supervise. The fifth to seventh grades help serve, taking twenty minutes out of school hours. The lunches are little more than self-supporting. Candy and cooking profit pays for equipment and for pupils unable to buy their own lunches. The need is to make the board of education realize the educational and nutritive value of good food.

Miss Steininger described the use of the cafeteria by a normal school domestic science class as a laboratory for experience, to try out equipment and forms of service, cooking foods in amounts of family size up to 12, and then in amounts to serve 50 to 100, to serve the clerical force, students, and faculty. A manager is appointed daily to take charge of food preparation and service. A stock girl has charge of equipment and supplies.

Miss Treat, of Minnesota, described the college cafeteria. She believes that the college cafeteria is an economy in labor and food—1.74 as much waste in dining-room system. The aim of the college cafeteria, in the standards set, reflects ideals and policies of the university and sets food standards. It must be a financial success; should be properly equipped. The service ideal is first; it is an all-university project, functioning through every department. It is educational in character. As for control, the concession plan is bad. The business office control should be financial only. It should link up to some educational department but not be controlled by it. The food standard should be high; the cafeteria should refuse to serve cheap products, for there is training and educational advantage in good food. Dietetic planning is necessary—with the aim of giving less variety in a day's meal, but plenty of variety from day to day. Careful supervision of service means that sum total of service gives proper calorific value. Portions are standardized. Counter service shortens time and is more efficient. The atmosphere should be peaceful and quiet, without confusion or hurry, with food properly arranged on counter. The room should be made attractive—if possible, give it the tea-room atmosphere. The policy should be, good wholesome food, as near cost as possible. The cafeteria should make no profit, and also tend to serve the above educational purpose.

Mrs. Fleet, chaperone Chadbourne Hall, University of Wisconsin, discussed the problem of acquiring and maintaining a home atmosphere in a dormitory housing from one hundred to five hundred girls, and at the same time maintaining discipline.

Miss Faith McAuley, of the University of Chicago, speaking on marketing for the institution, discussed the necessity for specific and practical knowledge of trade material along lines of content, method, business practice, and the economics of the subject, including cropology and commercial geography, distributive agencies, value and price factors. There is the finest opportunity in this field for the tie-up of education to a subject of practical value.

Dr. Hugh Payne Greeley, of Madison, gave a paper on the physician and the dietitian which is published in the Department of Dietetics this month, page 132.

Mrs. Madeline S. Mehlig, Red Cross Dietitian Service, representing the Chicago Dietetic Association, read a paper on the dietitian in the small hospital.

Miss Lenna Cooper spoke on "The Supervising Dietitian," from experience in the United States surgeon-general's office. She found that camp officials often did not know what to do with dietitians. She had usually to make her own place, a pioneer did excellent work planning menus, supervising service, and advising on special diet. There is general need for stimulation of work by closer personal contact and cooperation.

Papers were also read on equipment and insulation.

DEPARTMENT OF NURSING

Conducted by ANNIE W. GOODRICH, Dean Army School of Nursing and CAROLYN E. GRAY, R.N.

Please address items of news and inquiries regarding Department of Nursing to CAROLYN E. GRAY, R.N., Secretary of the New York Board of Nurse Examiners, 135 E. 45th St., New York City.

A SURVEY OF THE NURSING QUESTION

Postgraduate and Affiliated Courses—Ward Assistants—Care of the Health of Nurses—Prophylactic Measures

By M. T. MacEACHERN, M.D., C.M., Superintendent, Vancouver General Hospital, Vancouver, British Columbia

[Concluded from July issue, p. 70]

POSTGRADUATE AND AFFILIATED COURSES

This is the day of specialization and advanced training in all lines. It is therefore necessary to consider first, postgraduate courses, and second, the affiliation of smaller training schools.

In this hospital and a large number of others on our continent, postgraduate work is usually confined to the following lines: Surgery, obstetrics, pediatrics, dietetics, eye, ear, nose and throat. Speaking generally and in a critical way, I do believe there is something wrong and something lacking in our postgraduate courses. Annually the training school for nurses of the hospital here received several scholarships from various members of our medical profession of sufficient value to cover a six months' course in certain special work elsewhere, and I say frankly, and regret to say, that we have great difficulty in finding a place for such candidates where we feel they will receive a thorough training and wide experience carefully directed, which we desire they should have. There seems to be a loss of perspective in the arrangement of postgraduate work in our hospitals and a failure to recognize what these courses should be. Usually a large amount of work, which has already been thoroughly acquired in the first school, is demanded of these postgraduate nurses, and that time is lost so far as spending it in the more purely essential technical portion which she is seeking is concerned. It is argued, and possibly quite truly so, that any other course would interfere materially with the nurse-in-training. If so, there seem to be other arrangements which could be made, but such courses should not be offered unless sufficient in return can be given to justify calling them postgraduate courses. We all are aware that too often there is lack of strict supervision and of instruction. The course is too much as if one said, "Well, there it is, go to it, and get all you can." That method is all right in itself, for I do not approve of "spoon-feeding," as one of my college professors called it, but I do recommend systematic instruction with good supervision, so that a candidate can make the best use of her time. Of course there is a great deal to be said on the other side, as so often young women are selected for postgraduate work who are not suitable at all for any such special line. There are many cases that cannot be developed, a condition which must be discouraging and annoying to the superintendent of a training school who has to deal with such a pupil. Possibly, therefore, the cause of many cases failing in this respect is the fact that we do not select the proper nurse to take the course. Be that as it may, a well-arranged postgraduate course should embody the following features: First, well-arranged and thoroughly systematized instruction; second, intensive practical or technical experience and training along a particular line; third, expert supervision over such work; fourth, tried responsibility; and fifth, a final examination, oral, practical, and written.

This hospital will insist on such conditions being fulfilled in the future. The most recent advance along these lines is the addition of an instructor in the operating-room department, who will do the teaching and instruction; the instruction will be taken care of in like manner in the other departments where postgraduate work is being given. It seems to me that it is the duty of every well-equipped training school to give such courses for the advancement of nursing knowledge.

Coming now to the second question, that of affiliation, we find throughout our country that many of the smaller hospitals with smaller training schools are affiliating with the larger institutions; this condition now exists in the province of British Columbia, where there are some ninety to one hundred hospitals and a conservative estimate of forty to fifty training schools at least. The question, therefore, is, how can the larger training school help the smaller and help the nurse to acquire a broader training through a more widespread and diversified experience? They can offer affiliated courses, and, in connection with this hospital and others in the province, such arrangements have been made by several training schools, so that third-year nurses can come here and spend their final year, devoting their time mostly to operating room, maternity, pediatrics, and other specialties. The hospital desiring such privilege must measure up to certain requirements which must be complied with, and are as follows:

Rules and Regulations for Affiliating Pupils

"1. Nurses having had two years' training in their own schools are allowed to take their third year in the training school of The Vancouver General Hospital, provided, however, that their work had been satisfactory in the hospital in which they were training and that they are willing to comply with all the rules and regulations as laid down by The Vancouver General Hospital Training School for Nurses.

"2. All applicants must have the approval of the superintendent of nurses of their own training school.

"3. All applicants must have their third-year holidays before coming in.

"4. Nurses will wear the uniform of the school sending them.

"5. Nurses will graduate and receive their diplomas from hospital affiliating.

"6. Nurses must be prepared to demonstrate their ability in the making of various kinds of beds; bed baths, simple and temperature sponges; enemata; giving medicines; douches; charting; catheterization; local applications; general ward care; and preparation and general after-care of surgical patients.

"7. Provided nurses can comply with Regulation No. 6, the course for the third year will be devoted mainly to operating-rooms, maternity, pediatrics, and dietetics.

"8. In order that uniformity of teaching may be obtained, it is recommended that the following textbooks, which are in use in The Vancouver General Hospital, be used: Practical Nursing, Maxwell and Pope; Anatomy and Physiology for Nurses, Pope or Kimbers; Materia Medica, Paul, third edition.

"9. Nurses are advised to study the following: First-Year Nursing, Goodnow; Clinical Studies, Aikens; Essentials of Medicine, Emerson; Nursing in Acute Infectious Fevers, Paul."

In making application the following information is necessary and must be filled in by the nurse desiring admission to any of the courses:

APPLICATION FOR AFFILIATION COURSE

1. Name in full.
2. Home address.
3. Name of school in which you are training.
4. Are you single, married or a widow?
5. Date of your birth.
6. Are you in sound health?
7. Were you vaccinated against smallpox, and if so, with what results?
8. What preliminary education have you had prior to entrance into your training school for nurses?
9. Give name and present address of superintendent of nurses in charge of school where you are a student.
10. State number of beds in hospital where you are in training.
11. Have you received regular class instruction and lectures during your course of training in your hospital?
12. State length of time spent in the following departments of your training schools: Medical wards, male; medical wards, female; surgical wards, male; surgical wards, female; obstetrical wards; children's wards; care of infectious diseases; and operating-room work.
13. When can you enter?

The nurse graduates from her own training school though she has spent her final year here. Each pupil is on a two months' probation, and, if her service is not up to the standard, will be returned to her own institution. In this you will readily see that there is a distinct advantage to the nurse who secures a broader training than she could secure in her own institution in the final year, but there is a disadvantage to the hospital in losing her services during the third year when she would be most useful to them. If the smaller training schools, however, are to continue, such affiliation must be carried on, because we must not graduate nurses without a thoroughly broad training along nursing lines. There does exist in the province a lack of uniformity of training, and during this year an effort will be made through the British Columbia Hospital Association to establish a standard curriculum for all training schools in British Columbia, a movement which will help affiliation considerably.

THE WARD ASSISTANT

There is a greater or less shortage of applications of young women with the necessary educational advantages to take up the nursing profession and a large number of institutions throughout our country are short of nurses. Why this should be, is difficult to say, and it is impossible to point to any particular factor causing such a shortage. I do, however, feel that there is something lacking, and this fault may possibly be due to the modesty of the nursing profession. I refer to the failure of the nursing profession to impress on the world at large the changes and advancements in the profession, and the actual work that nurses are doing and that they are required to do at the present time; in short, there seems to be a lack of publicity. The world at large is not impressed with the fact that the nursing profession is the ideal one for womanhood, that it is a grand and noble work, that it stands for the highest and best ideals as well as for many additional things which could be mentioned and to which more publicity should be given but to which, undoubtedly through modesty I suppose, it is not. Indeed, I am afraid in these strenuous times with socialistic movements so rampant that both the nursing and medical professions may be brought closer to a more commercial plane unless we keep our ideals constantly before us. However, the fact is that we find fewer young women entering the profession, and it is therefore necessary that we must see what the cause is and apply the remedy.

Possibly the linking up with the higher educational development may be more of a stimulus for women to enter this profession. Possibly the great prominence now being given and interest taken in the nursing profession throughout our land will stimulate a larger number of young women to enter it. On the other hand, possibly the shortage is due to the fact that there is a greater demand than ever, as all training schools are growing and the field is enlarging. It is thought by some that the standard required for admission to many training schools is too high, but this is not the case, provided the young woman is offered a thorough training and equipment which will be a great asset to her through life. Then again, there is the question of remuneration or the financial return after graduating. Nurses' fees have gone up in the last year or two and I do not think they will ever come down again. Provided the nurse doing special work gets continuous work, the fees now seem fairly satisfactory, but if she does not get steady work she may have some discouragement in her profession. At all events the cause underlying such a shortage requires our serious consideration and I have only two thoughts to leave with you: First, the educational campaign, so to speak, to impress on the public the importance of this profession, and second, the improvement of all training courses and linking them up with the higher education so far as is practical, offering the nurse all we possibly can; that is, I consider that it is up to the nursing profession itself to make or unmake conditions which are present or which may arise.

In reference to a paragraph quoted in the introduction of this paper, mention was made of the ward assistant or helper. Ward assistants were originally introduced into the Vancouver General Hospital military department some two years ago, nurses being exceedingly scarce, owing to the war. They are still serving in this capacity and the system has been quite satisfactory. They are not the so-called "V. A. D's," as they are paid a living salary and provision is made for room, board, and laundry. During the war such young women were very easily secured, as they felt they were doing a service. During the epidemic they were used extensively throughout our emergency hospitals, but unfortunately we were not able to give them the necessary instruction to make them of the greatest use. These young women do the housekeeping duties of the ward, duties which I do not need to enumerate but which, as you know, take up a good deal of the time of the nurse. The graduate nurse attends to all medication, treatments, and dressings, as well as charting and supervising the meal service. This arrangement, I may say, has been exceedingly satisfactory and, in fact, saved the situation for us when nurses were absolutely unobtainable. These helpers or assistants are not generally used in the civilian wards of our hospital, though they were during the influenza epidemic. The reasons why they have not been used are: First, we do not just know how far it might interfere with the training of nurses; second, it is a financial question and involves a greater outlay of money than is customary; and third, the question arises, will it tend to make graduate nurses less resourceful when out in private practice, to have become used to such assistance in the hospital? I am not in a position to answer these questions. They can best be answered by the leaders in the profession. However, if we have the right kind of young women in the profession with the proper ideals before them, the third objection will not obtain. There are certain definite advantages in the system both to the nurse and to the patient. The present system means that a large proportion of a nurse's duty, and, consequently, of her time, is taken up with household matters which she continues to do day after day, over and over again, approximately three hundred and sixty-five days a year for three years. Is it not true

that every nurse in her training usually makes three to four thousand beds at least? Do you not think she would be efficient at this particular duty when she had made, say, three or five hundred? Why not take the remainder of her time for the true nursing science, for the training of observation, and for application of nursing principles? We depend greatly on efficient nursing observations and refer at all times to the nurses' notes which are the outcome, of course, of well-trained observation. The duty of taking notes is admitted as being exceedingly important, and more time allowed for such observation and for its expression is necessary today. Furthermore, under this system, more time would be allowed for the actual instruction and teaching, which would be a distinct advantage in the training. There is, therefore, a great deal to be said in favor of this system so far as the training of the nurse is concerned, when it is put on a proper basis.

In regard to the advantage from the hospital administration standpoint, we all know that the innumerable abnormal dispositions we have to deal with demand a diversified attention indescribable; scores of whims and desires, the so-called "little things," may arise which I cannot enumerate, and often the attention to some little desire or request or whim may do the patients more good than medicine and keep them happy and contented and easy to wait on; in short, they take their treatment better when these things are regarded. In such cases it is almost impossible for a nurse to attend to these, as she is busy with the more essential matters pertaining to her actual nursing service, and yet I believe that these little things which seem to us so unimportant and nonessential to the patient's recovery, are very important after all, and, if regarded, might materially help to keep up a fine *esprit de corps* among the patients. We all know that a cranky patient impedes efficient service, makes nursing a burden, in short, keeps everybody unhappy around the ward, and, looking at it from a hospital administrator's standpoint, I am beginning to feel that it is our duty and distinctly to our advantage to maintain a good *esprit de corps* among our patients and remember that we are at all times dealing with people at a time when their dispositions are more or less abnormal.

I think I am safe in concluding that some day this system of ward assistants will be generally adopted throughout the civilian wards of our hospitals and put on a sound basis with classes for instruction arranged, and thus become a recognized feature of our institutions.

During the past two years we have had the experience in this hospital of training nursemaids at the infants' hospital, an experiment which seems almost on a parallel basis. These girls are taken in for six months' experience and training, receiving instruction; they pass an examination and are eventually turned out as nursemaids, many of them finding their way to good families where they secure positions looking after well babies. I may say from our experience that this arrangement is working out satisfactorily and does not in any way interfere with the nurses training in this institution. In England there is a school which trains a high-class nurse, who takes standing equal to that of the trained nurse. She is a real child nurse. She takes charge of the training of the child and his care in sickness or health until he is of school age.

PHYSICAL HEALTH OF NURSES

If the hospital is going to live up to its health ideals and its health demands, it should necessarily adopt measures to put the health of its staff foremost. The remarks which I intend to make might apply to the entire personnel, but in this paper I am referring only to nurses.

Many young women desirous of entering the profession of nursing are physically unfit for such a calling and cannot stand the arduous duties which are before them, whereas in other cases persons who are considered physically unfit or below par may develop into healthy, robust young women. During the past eight years I had the opportunity of studying the health problem of nurses very fully, and this paper will embody, as far as possible, my conclusions on the matter.

It is the responsibility of every hospital management, especially on the medical side, to see that adequate interest and care is taken in the health of the nursing staff, and this phase of hospital management must be considered more seriously by our hospitals than it has been in the past, for the army has taught us many things and, in fact, has revolutionized the medical service. Routine examinations have unearthed conditions which would have been a serious consideration to the applicant if he had been passed over and sent into service. Likewise our nurses must have a well-organized medical service whose duty it is to discover any disease or physical unfitness, as well as to treat such conditions as arise during the training. Today there is no excuse for any young woman who is physically unfit to enter the profession and later on to break down in health. My experience is based on a large number of physical examinations and observations of nurses who passed under my care during my years of hospital work. I find that prospective applicants can always produce a certificate of health, usually from their dear old family doctor, and they tell me invariably that he did not examine them but issued the certificate because the family was always healthy. These girls at one time entered our training school and were not examined till the end of their probationary time—about two months after they entered; then it was always found that from 8 to 10 per cent were unable to continue their duties and must be rejected. This often causes very serious disappointment to the young woman, to the family, and to the superintendent of nurses, for not infrequently do we find in such a case that there are fine prospects of a particular person making an excellent nurse. However, this 8 or 10 per cent had to be dropped. It was next decided that we should adopt a certain prescribed medical form for physical examination, of a stereotyped nature, and that the prospective applicant should have a doctor fill it out when applying. This form would necessitate a complete examination and includes the age, previous occupation, personal history, and family history of the applicant; the physical examination itself covers the applicant's development, nutrition, temperament, etc.; eye, ear, nose, and throat condition; respiratory system; circulatory system; digestive system; nervous system; glandular system; integumentary system; locomotor system; and genito-urinary system. The report of this examination is followed by any remarks or recommendations of the family physician.

From this it can be seen that a complete examination is necessary, and if a doctor has to fill this in, he will usually take more care to examine the person. This form was adopted and it was further arranged that a second physical examination should be made by the hospital staff on the first day, or day of admission, and, in this way, any physically unfit candidate who passed her own doctor was further checked over by the hospital staff according to our standard; her unfitness was therefore discovered early and before she had developed a love for her future work. Occasionally at these examinations now one or two may be found who are not recommended, whereas one or two may be recommended for two months' probationary

physical trial. With this system very seldom do we find anybody at the first examination to be rejected, and there is not more possibly than 1 or 2 per cent at any time. The third physical examination takes place after two months' duty, records of all being kept. As a result the number of cases who are rejected on physical examination and the number who break down in their training is practically nil, at least not worth regarding. Today we insist on a high standard of health, and systematized and rigid examinations.

In the physical examination of nurses on admission, the following conditions have been found: Heart murmurs and irregularities, varicose veins, fallen arches, diseased tonsils, pyorrhea alveolaris, spinal curvature, goiter, tuberculosis, diphtheria carriers, malnutrition. It is rather remarkable and interesting that in several instances we have found diphtheria carriers from our routine cultures of nose and throat. Many cases have to be referred for special examination to the different specialists and the different laboratories and reports received from the respective experts. No trouble or expense is spared, and the examination is made as rigid and efficient as possible; in fact today our physical examination is very difficult and one of the hardest to get by if there is any evidence of physical unfitness. In many cases extensive consultations and deliberations may be necessary before acceptance or rejection.

There are certain physical conditions, however, that are not detrimental to a nurse's training and may be improved with her work. Very often indeed do we see nurses improve and put on flesh, owing to the regular life, regular sleep, regular diet and constant hygienic conditions; the latter the hospital must provide. When there is a history of rheumatism or tuberculosis or such diseases as are regarded as more or less protracted, recurring, or incurable, the candidates are rejected and are not given a chance of continuing. We have found in many cases that the nurse usually gains flesh, especially during the probationary period, and we have seen girls who were considered delicate leave the school physically robust. Therefore, I trust that you will realize the importance of careful physical examination of all nurses before they enter on their training, as well as other examinations throughout their course.

In regard to the health of the nurse while in training, this is another feature. The minimum illness should be maintained and this can only be done by an organized medical service and a daily sick parade by a competent hospital official. Many can secure treatment to carry on while on duty and by such a parade early reporting of disease is made more customary. Others must be confined to bed and all must receive the best medical advice and consultation at the disposal of the hospital for diagnosis and treatment.

The incidence of disease here amongst our nurses is very low. During the influenza epidemic, of course, we had a large number, but came through with one of the best records possible. This was due to the expert medical care, the very early treatment, and the careful guidance of convalescence given to the nurse. The marvelous health record of our nursing staff throughout the terrible epidemic can not be surpassed anywhere, and to my late assistant, Dr. Mahony, should be ascribed that credit, as is well known to all.

One disease particularly more prevalent than any other among nurses is the so-called "sore throat." Careful examination on admission, with removal of tonsils if necessary, and the constant use of gargles throughout training will prevent many such throats. Fallen arches were at one time prevalent but, with more attention to footwear, this trouble has decreased rapidly. The incidence of infections of fingers is still high and most cases prove distinctly that the safety pin is the greatest offender. More nurses from our infants' hospital develop such conditions than from any other portion of the institution, and the prevalence of safety pins there explains this. Another condition with which we have considerable trouble is eczema or dermatitis, which develop from the irritating solutions in cases in which there is a tender and susceptible skin. These are indeed hard to deal with, but with treatment and care along prophylactic lines, the hands will eventually become hardened and withstand the irritating solutions. The incidence of infectious diseases should at all times be low. In conclusion, there is a great deal which could be said along these lines and many other conditions that I could enumerate. Undoubtedly the use of such serums as typhoid, anti-diphtheria, and others have had a wonderful effect and are much approved by all.

To summarize, the health of the nursing staff requires, first, rigid examination on admission and followed up as necessary; second, the daily sick parade at a stated hour; third, organized medical service for sick nurses; and fourth, prophylactic measures for diseases, especially for the more prevalent.

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NATIONAL LEAGUE OF NURSING EDUCATION MEETS

Training of Attendants—Eight-Hour Day for Pupil Nurses —Rank for Army Nurses—Among Important Questions Discussed

The 1919 meeting of the National League of Nursing Education was held in Chicago June 24-28 with headquarters at the Congress Hotel. The address of welcome was delivered by Mrs. Ira Couch Wood and the response by Miss S. Lillian Clayton, the president of the league.

Revision of Constitution and By-Laws

The committee on revision of the constitution and by-laws felt that owing to the great changes incident to the war, the increased prominence of the nursing profession, and the multiform duties which it is taking on in public health work, etc., a number of revisions were necessary, to include an annual instead of a biennial meeting, annual election of officers, appointment of a paid interstate secretary, establishment of headquarters, and an increase in the annual dues of from $3 to $5. Provision for a more definite organization of work of state and local leagues was recommended in order to avoid multiplication of effort.

Report of Committee on Education

The report of the work of the Education Committee was probably the most interesting of any report presented, in that its plans and work already accomplished will be of incalculable assistance to nurse educators in the solving of their many problems.

The committee has been strengthened by the addition of one other member, representing the group of public health nurses (since the committee has under consideration a number of matters which are closely related to public health nursing).

Measures to carry on a campaign in support of shorter hours for pupil nurses through the publication of pamphlets giving the arguments for shorter hours and pamphlets for superintendents of nurses and other officers of hospitals, outlining methods of organizing training schools on an eight-hour basis, were voted upon. These pam-

phlets, "The Case for Shorter Hours in Hospital Schools of Nursing," and, "Suggestions for Establishing the Eight-Hour Day in Nursing Schools," have been issued under the auspices of the National League for Nursing Education, the American Nurses' Association, and the National Association for Public Health Nursing and are ready for distribution. Copies may be obtained by sending 30 cents to Miss Isabel M. Stewart, secretary of the Education Committee, Teachers College, Columbia University, New York City.

The readjustment of student work in hospitals with the idea of eliminating such of the routine duties as are known to be relatively uneducational. The principal plan discussed was the use of paid helpers.

Measures to effect the grading or classifying of training schools.

Owing to the immediate needs of workers in the public health field the National Organization of Public Health Nursing was asked to organize a campaign among senior nurses and recent graduates for the recruiting of nurses for public health work. Superintendents of schools of nursing were also asked to cooperate to consider allowing some reduction of time in other departments of the hospital and in encouraging third year students to fit themselves for public health nursing.

Training of Attendants

The committee on training of attendants drew up a tentative course and presented it to the executive committee, but it is still subject to alterations. The public health nurses are strongly against institutional training for attendants and believe that such training could be best given in housekeeping centers, and that the course should be short—less than a year. The course, as outlined by the committee, will be based on the Red Cross textbook; it will require for entrance the age of at least eighteen years; the ability to read and write English and to keep simple bedside reports; and good physical condition and moral character; it will last for one year, nine months in an institution and three in a public health center; the subjects included will be elementary nursing, twenty hours; cooking and dietetics, twenty hours; care of children, five hours; care of the chronic sick, five hours; care of accident patients, five hours. This course will not be eligible for the Smith-Hughes appropriation, as it does not include the requisite number of hours.

In regard to the types of hospitals in which these courses will be given, it is emphasized that hospital training schools are *not* suitable. Those suggested are sanatoriums for tuberculosis patients, homes for the aged, for the insane, for nervous diseases, children's convalescent homes, etc.

Two subjects were suggested for addition to the curriculum—ethics, three hours, and anatomy and physiology, three hours.

California has already passed a bill providing for nursing attendants, and schools for their training are being established. The course differs somewhat from that recommended by the committee, and includes instruction in obstetrics. The power of administration of the schools rests with the board of health; the bill provides for their affiliation with each other and with other institutions; the courses are to be taught by a registered nurse.

The committee decided that the trained attendant would fill a real place in the care of children, of the chronic sick, etc., but that her status must be rigidly defined by law or else inferior nursing will result.

Vassar Preparatory Training Course

This course was successful in meeting the war-time emergency. Many of the students are continuing their training. It is decided that such cooperation is practicable, but that, if it is to continue, certain changes are necessary. Closer affiliation of the college with the hospitals is advised, and it is realized that the financial question must be dealt with, for the college summer course was more costly than peace-time needs would justify.

How the Army Nursing Service Met the Demands of War

Miss Dora Thompson, superintendent of the army nurse corps, said that on the day we declared war, we had in our regular army corps 230 nurses and 170 in our reserve. On the day that the armistice was signed we had 3,532 regular nurses and 17,956 reserves. The Spanish-American war had demonstrated the value of graduate nurses, and an act of Congress established an army nurse corps. We had at this time 100 army nurses serving in post hospitals in this country and in the Philippines. By 1916 their number had increased to only 150, but it took a sudden jump at the time of the mobilization on the Mexican border.

The reserve force consists of enrolled Red Cross nurses, and it was due to Miss Delano that this force was established. The war requirements waived registration, though this requisite has since been reestablished; nurses were received between the ages of twenty-one and forty-five; nurses of the allied countries were received.

Many Catholic nursing orders were represented, and Catholic sisters served overseas in Base Hospital 102. A great many colored nurses were enrolled and served in the cantonment hospitals for negroes.

In spite of the great numbers of enrolled nurses and the fact that at the signing of the armistice many applicants were on file, it soon became apparent that if the fighting continued the supply of nurses would be exhausted. On this account the Army School of Nursing was established by the War Department, described later by Miss Annie Goodrich. This school included a course for nurses' aids for whom the Surgeon-General had asked.

The demand for nurses was very great, coming, as it did, from many cantonment hospitals of 1,000 beds, from general post hospitals, from aviation stations, debarkation and embarkation hospitals, hospital trains, etc., and a large number were required by the physical welfare division at Washington, which looked after the health of the innumerable girls in that city doing war work.

Nurses are still retained in the service for work in the base hospitals in this country, in demobilization stations, in Porto Rico, and in Russia.

One of the important advances for nurses in the war was the recommendation of the Surgeon General, approved by the Secretary of War, that the ward management of military hospitals be given to a nurse. This placed her in authority before a non-commissioned officer. Formerly the ward was in charge of the ward master, an enlisted man.

Work of the Navy Nurse Corps

The work of the navy nurse corps, according to Mrs. Lenah Higbee, its superintendent, is chiefly distinguished for its variety. The navy nurse was not only a nurse, special and surgical, but she was a teacher, dietitian, cook, x-ray operator, clinician, and confidant.

Serving, like the army nurse, in cantonments in the early days of our mobilization, she had the most primitive conditions to deal with. In many of the hospitals even water had to be carried in from outside. This state of affairs, of course, was later much improved.

One of the most interesting indirect results of the war was the establishment in Haiti by the Navy Department

of a training school for native nurses (described, in THE MODERN HOSPITAL for April on page 273).

Five navy base hospitals overseas were organized by the Red Cross and turned over to the navy. The navy nurse served not only in France and America, but in hospitals in Ireland and Scotland and on ships in the transport service. In her work, also, the development of the executive nurse was a prominent feature.

Red Cross Nursing Service at Home and Abroad

Miss Clara D. Noyes outlined the work of the Red Cross nursing service. It was begun in 1906 under the auspices of nursing organizations. A committee appointed by the American Federation of Nurses outlined an organization for the American Red Cross. The Red Cross was made part of the army and navy corps by the Secretary of War, and, by a proclamation of the President, made the only outside organization to hold this position.

The Bureau of Nursing Service, organized for the making and distribution of dressings and the assignment of nurses in 1915, became in 1917 the Bureau of Field Nursing Service. Through it 10,877 nurses were supplied by the Red Cross to the army, to base hospitals, to hospital units, to training-school units, and to the public health service.

Fifty thousand nurses were asked for from the training schools and, for the assignment of the great number who replied, the United States was divided into thirteen divisions through which the local and state committees functioned. This decentralization was found to be most efficient.

The enrollment drive, begun June 3, 1918, was most effective, enrollments reaching the number of 100 a day. The withdrawal of nurses from the communities proved so serious, however, that in August at the request of the War Department, the Red Cross understook a minute investigation of the nursing resources of the country, to include all types of people caring for the sick. The influenza epidemic interfered seriously with this important work, which was incomplete when the armistice was signed.

The work of the Red Cross has been much more than caring for the wounded, important as that has been. It is playing an important part in the movement for public health service, both here and in France; in Russia it has established a training school for Russian girls; and its most conspicuous piece of relief work at home was in the influenza epidemic.

The Red Cross today has three thousand chapters, a membership of twenty million adults, and thirty-five thousand enrolled graduate nurses. Its big future, now that peace has returned, lies in the development of public health work.

Contribution of the Army School of Nursing

Miss Annie W. Goodrich, the dean of the school, said that it received in five months 10,689 applications; of these 5,267 were accepted; 199 students were placed on duty and 567 were held ready for assignment. The chief reason for the army school's existence is its service in developing executive nurses, familiar with army routine and army ways, and it is important, too, in maintaining morale which is likely to slump in times of rest.

The preliminary course, formerly given at post hospitals, is now concentrated chiefly at Walter Reed Hospital. Its great work has been in the upbuilding of nursing standards, even in the face of a great emergency, and the timely issuance of a standard curriculum.

The chief disadvantage in the army training school training is the poor clinical experience furnished by an army post which consists largely of healthy men at the most healthy period of their lives. On the other hand, however, there is a fair proportion of illness, especially where the hospital service is extended to the wives and children of the officers. The great advantages are the superior teaching facilities which are afforded, and the large graduate body of nurses of high standards which the school produces.

Under more stable conditions the school will provide a better faculty and arrange for affiliating courses in civil hospitals. It is believed that the army school can be made a model school of nursing.

How the Civil Hospitals and Nursing Schools Met the Test of War

The shortage of doctors and nurses, servants, and supplies, made a very serious situation for civil hospitals. It was met, according to Miss Elsie Lawler, superintendent of nurses, Johns Hopkins Hospital Training School, by the pupil nurse. Many women entered nursing on account of the war; the publicity campaign of the committee on nursing of the Council of National Defense was extremely successful. Schools and nurses' homes were enlarged, and the great numbers of pupil nurses entered heartily into the necessary program of conservation of food, material, and laundry. The advantages of this period of nursing education were the spirit of cooperation which was shown by everyone and the intimate relation which developed between the graduate and the pupil nurse. The disadvantage was, of course, the inevitable lowering of standards in war time. There is no need, of course, to tell of how well the pupil nurses met the big test of the influenza epidemic.

War and Post-War Activities Relating to Nursing

Miss Sara Parson, chief nurse of Base Hospital No. 6, A. E. F., which cared for 25,000 men up to the time of the armistice, praises the work of the nurses, to whom the medical officers left so much responsibility that their position was much like that of an intern. She has the following criticisms to make of the service: Under the military organization the work is hindered by divided authority, and special difficulties are presented by the nurses' lack of control over the orderlies; the limitations of equipment were serious, the nurses sometimes finding it impossible even to obtain heat by which to boil instruments; the indirect communication with the director of nurses prevented the smoothest working of exchanges, etc.; there was no way adequately to supervise the irresponsible nurse.

To remedy the defects of the system, Miss Parsons suggests (1) a distinctive uniform for officers, (2) absolute rank with pay; (3) authority for the director of nurses to decide exchanges, etc.; (4) lay women for many jobs, such as preparing diets, taking charge of supplies, etc.; (5) provision for emergency necessities.

Miss Grace Allison, chief nurse of Base Hospital No. 4, considered herself fortunate to be associated with the British. Under their organization, which differs in many respects from ours, the orderlies elect their service in the medical corps and receive seventy-five hours of instruction, after which the matron (similar to our chief nurse) passes on their fitness. The nurses, under the English system receive service and quarters similar to those given to officers.

Miss Amy Trench, chief nurse of Base Hospital No. 3, told of the special problems confronting the army nurse in the demands of the vast paper work of the army, in the necessity for keeping up the morale of the patients, and in the frequent absence of medical officers. She be-

lieves that one of the results of this work is that more will be expected of the head nurses than formerly. There will be more executive positions to fill and more executives to fill them.

Inspection of Cantonment Hospitals

Miss Anna Jammé, government inspector of cantonment hospitals, found that in some cases in the early days of the war the equipment in these hospitals was very meager; that food for the patients was poorly served; that the social hygiene wards were dirty and uncared for, "similar to a low-grade penal institution"; that the care given patients in the pyschopathic wards consisted simply of segregation; that in one tuberculosis ward there was no nurse in charge and that the patients were disciplined by being put upon a bread-and-water diet for three days.

When nurses were put in charge instead of the old ward master a transformation took place, although the nurses still had to struggle with the difficulties of inexperience resulting from their constant change in position.

Results of Organized Publicity in Interesting the Public in Nursing

The paper on this subject by Miss Carolyn E. Gray, secretary of the New York State Board of Nurse Examiners, will be published in this department later.

The Present Condition of Supply and Demand

Mrs. Bessie A. Haasis, educational secretary of the National Organization of Public Health Nursing, said that if it were simply a question of quantity the situation might be summed up by saying that the demand is overwhelming and the supply inadequate but improving. Since it is a question of quality as well as quantity, she went on to draw attention to a few interesting facts. During the past year there has been an unprecedented increase in the demand for public health nurses, both specialists and the kind who can carry on generalized work. There has been in particular a demand for school nurses qualified to do tuberculosis work, nurses for child-welfare work and mental hygiene nurses. An impression that there has been a great increase in demand for industrial nurses is not borne out by the experience of the National Organization for Public Health Nursing. This is partly because of a misunderstanding in regard to what constitutes an industrial nurse. Both nurses and employers are apt to think of an industrial nurse as one who does first aid work. The Red Cross peace-time program of developing community nursing has stimulated a demand for a nurse who can go to a community and build up from the very bottom an organization of one to twenty-five nurses. The labor organizations, which formerly have been somewhat hostile to social insurance, have some of them come to favor it, and this renders probable the passage of social insurance legislation, which will create a demand for a vast number of nurses.

At present there are nine eight-month, postgraduate courses in public health nursing, four four-month postgraduate courses, and seven summer courses of not less than six weeks in length, in addition to a number of courses which have not yet been recognized by the national organization. Twelve of these courses are taking undergraduates, and postgraduate courses are projected in four cities. In addition over one hundred hospitals are giving their senior students from one to six months in public health nursing during their senior year.

It is an injustice to send a student to a visiting nurse association, to a city board of health, or any public health nursing agency which depends on students primarily for the work accomplished—any organization which can not guarantee three hours, or preferably six, class work a week, and can not keep a check on the work done.

The Nurse as a Factor in the Prevention and Control of Venereal Diseases

In refutation of the idea that is being promulgated in some quarters that "nurses have been too highly trained" Assistant Surgeon-General C. C. Pierce said that careful observation clearly indicates "that to reduce the standard would be unwise; the public-health nurse needs *more* education rather than less," . . . she must understand not only nursing but psychology, economics, and sociology. Another false impression to be combatted is that "training a nurse in hospital unfits her for public-health work . . . that nursing in a hospital is concentrated on cure rather than prevention." On the contrary, the hospital experience is essentially necessary if the visiting nurse would understand and be fully qualified to meet the phases her work constantly presents.

He said that "fifty thousand public health nurses would be needed to fill the requirements of all the legislation now pending before Congress and the various state legislatures. This includes nurses who are going to do rural health work, sanitation, tuberculosis, and public school inspection. In venereal disease work the clinic cannot work without one or two nurses not only for work in the clinic but for following up those cases by visiting them in their homes." It is frequently asked if it will not be unusual to follow those cases into their homes, but time and again when a man knows his situation he wants the nurse to come into his home and see if his wife and children have not been already infected. The nurse should have a very broad viewpoint on the sociological and economical aspect and bearings of the case. The necessity of making various social agencies realize their duty in regard to venereal disease is great. In the past, most hospitals would not take patients suffering from those diseases. There must be a determined effort toward the hospitalization of persons infected with these diseases, not only to cure but to prevent the spread through homes and factories and workshops.

Miss Isabel M. Stewart, of the department of nursing and health, Columbia University, spoke of the work the public schools might do. She deprecated the idea of inexperienced high-school girls being given the technical studies in nursing but thought the time is coming when they will receive instruction in preparatory studies, fitting them for a nursing course. Bacteriology, hygiene, chemistry, and nutrition are branches suitable to be taken up by a high-school girl.

Miss Annie W. Goodrich did not see the necessity for giving young girls entrance into professional training. How anyone can fail to understand the maturity of judgment necessary for a trained nurse was, to her, inexplicable. "I protest against the care of a child's nurse being given to a sick child." Children's nurses have no business with a hospital training-course, leading them to fancy they can fit themselves to care for ailing children. Babies, even more than grown people, need the highest class of nurses—"babies can't complain." A young woman just out of high school is not matured enough to assume the responsibilities of the training for a public-health nurse. Even a college girl does not begin to appreciate the needs of the situation.

Miss Clara D. Noyes, of the Red Cross Nursing Service, Washington, D. C., spoke of the $15,000 fund, recently appropriated by the Red Cross for the preparation of instructors. Many of the schools have been compelled to adjust their courses to meet the need of instruction in

public-health work, and there is a demand for instructors. The Red Cross has appropriated money to be used in scholarships and loan funds, and it is surely as fitting to use $15,000 to prepare instructors as to appropriate money for public-health nurses.

How We Can Secure Better Cooperation and Assistance of Head Nurse and Supervisors

Miss Parmella Doty believes that in the development of classes for nurses under trained instruction, we run a serious danger of loss in pushing aside the teaching head nurse. The development of nursing education has passed through the following stages: (1) in which the instruction was given almost exclusively by the teaching head nurse; (2) in which the pupil nurse is still on duty in the wards, receiving instruction from the head nurse but also attending classes; (3) in which the administrative duties of head nurse have greatly increased, leaving her no time for teaching, and in which much more systematic class instruction is given. In this period lies the danger of divorcing theory and practice.

The solution lies in cooperation between head nurse and instructor. To make this effective, of course, some system of standardization is essential. It is important that the head nurse and the instructor realize their common aim; it has sometimes been a serious criticism brought against the head nurse that her interest is too apt to be confined to smooth machinery. She can assist greatly in helping the pupil nurse to apply her theoretical training by insisting upon bedside charts and verbal reports, and by asking questions. It must never be forgotten that the head nurse is a teacher as well as an executive.

Recent Experiments in Nursing Education

Miss Claribel Wheeler, superintendent of nurses, Mount Sinai Hospital, Cleveland, said that the pre-nursing courses, at the colleges included both resident and non-resident groups. The colleges which gave them were Vassar, Teachers College of Columbia University, the Universities of Colorado, Iowa, and Cincinnati, and the Western Reserve. At Cincinnati the course was given only to the regular students and to the probationers of Cincinnati hospitals. Teacher's College gave a three-months' course preparing pupils for entrance to the Army School of Nursing and base hospitals. This course will not be repeated. At the University of Iowa a summer course in two six-week sections was given to twenty-eight students, some of whom were students at the university and some regular applicants to nurses' hospitals. Experience here showed that the work was both too strenuous and too theoretical. At Western Reserve the students were recruited directly through the university and nursing schools. The course was given in two five-week sections. The students met college entrance requirements, attended lectures at the medical school, and later entered schools of nursing in the city. The disadvantages of this course were the concentration of so much theory in so short a time, the difficulty of study in the heat of summer, the distance which students had to travel to reach the classes, and the difference in the regulations of the training schools. The advantages were that the schools received a larger number of students and the students received expert college instruction and a solid background.

A questionnaire was sent out to the twelve schools receiving students from the preliminary Vassar course. To this course, 459 students were admitted, of these 274 were admitted to training schools, and about 200 are still in training. Some of the training schools found some difficulty in putting these students through, other did not. The big difficulty seems to be the lack of early practical training and the fact that the two remaining years are too short to make it up.

Among the points which the experiment seemed to demonstrate are that nursing technique is best taught in the hospital ward, from which, however, routine labor should be eliminated; that in receiving these college students, the training schools benefit by the high class of women; that colleges are better equipped than training schools to give the scientific background, but that this must be correlated with actual practice, and, finally, that a ten-weeks' course is too short, except for college students, and that summer is a poor time to give it in.

Cooperative Teaching

Miss Elizabeth Reid, Rochester General Hospital, Rochester, N. Y., said that cooperative teaching has become a settled fact at Rochester, owing to the shortage of nurses and instructors. It is economical because teachers need spend none of their time filling in; the classes come at definite days and hours, and, as the same thing is taught by the same instructor in each school, no time is lost in preparation for different classes.

A feature of this course is the two-hour conferences for instructors in the different schools. Different suggestions are actually tried out, which sometimes have resulted in complete revisions of demonstrations. There is, also, an added incentive for good work when one does not work alone.

Making the Students' Practical Work More Profitable From an Educational Standpoint

Miss Elizabeth Burgess, inspector of Army Nurse Training School, Washington, D. C., said that the practical work of the student is profitable in many ways—to the patient, to the hospital, and to the student—to the latter in particular since it provides opportunity for drill in the various nursing procedures, makes possible familiarity with the clinical aspects of disease and provides needed opportunity for growth. Actually, the practical experience of the nurse often falls short; for instance, a course may be completed without training in the children's ward, usually because there is no children's ward to go to; without diet kitchen experience; after a course including ten or twelve months spent in the operating room and one month only in the care of patients; after a course including one year spent on special duty with private patients; after a course three-quarters of which is spent as a head nurse in charge of other students. Experience in the care of cases of contagion and mental and nervous diseases is lacking in the majority of cases.

In most schools the probationers are the most interested group of students. The opportunities for learning are much greater in practical work, but it is robbed of much of its value by the mental and physical weariness consequent on long hours of service; by the lack of relaxation and opportunity for refreshment; by the repetition of procedures longer than necessary for perfecting technique; by the lack of time to make connection between class work and practice; by the impossibility, owing to lack of proper equipment or lack of time, of carrying out the procedure in the ward as demonstrated in the class room; by service in one department extended beyond the time when there is new material or opporunity for acquisition of knowledge; by lack of stimulation due either to entire lack of criticism or to constant fault finding; by the requirement of the student of routine work such as might be performed by maids after it has ceased to have an educational value for her, and by the division of duties

in the wards so that a certain individual always does a certain group of things.

Some of the conditions which Miss Burgess believes would contribute toward the educational value of the practical experience are: Hours not exceeding eight; instruction always proceeding from the simple to the more difficult duties; stated responsibilities for each student, including a definite number of patients for whom she is responsible; head nurses chosen for teaching ability as well as executive ability; nurse instructors who give much more attention and time to teaching than they do in the majority of schools today.

Affiliation of Hospitals

Affiliation was suggested as one means of caring for the predominantly large number of surgical cases in hospitals. Affiliation is also necessary to afford a general training to male nurses, who are especially useful in institutions for mental diseases but who can not there receive full training. A number of superintendents report excellent results from the work of the male nurses. The important thing is that he must not be treated or regarded as an orderly.

In order to make affiliation practicable, nurses' helpers are necessary. They do all the ward work for from $25 to $40 a month and receive no training. The students are then started on the actual bodily care of the patients.

The principal difficulty in the way of affiliation is in the expense involved.

Policies for the Coming Year

At the final meeting it was decided that the league needed an interstate secretary; that the league should further the cause of rank for nurses (a committee was asked to draw up a resolution to present to Congress); that publicity was desirable to educate lay people on nursing questions and to increase the attendance in the training schools. The league stands firmly for the eight-hour day for pupil nurses, and its position is fully outlined in the pamphlets which it has issued to send to superintendents. It is prepared, though unwilling, to resort to wider publicity to achieve this end.

The position of the league on nursing attendants is outlined in the following resolution:

Resolved: That in the training of attendants the factor governing the length and the type of training should be the physical condition of the patient rather than his financial resources.

That attendants should be prepared to care for the following types of patients: Convalescent patients, aged and infirm, chronic and well children, and in other cases to supplement the service of the graduate nurse and when required to assume the duties of an intelligent mother.

Further, that in preparation for these duties, attendants should meet the following requirements and be given the following instruction:

Entrance qualifications: Age, eighteen; present evidence of good physical condition and moral standing; ability to read and write English and to keep simple bedside notes.

Type of institution in which training may be given: Homes for incurables; homes for the aged and infirm; homes for crippled children; tuberculosis sanatoriums, institutions for mental and nervous diseases and for epileptics.

Length of course: Six months in an institution, during which time the theoretical and practical instruction is given, and six months under supervision and with salary either in an institution or private home.

Outline of theoretical work: Ethics, five hours; household hygiene, personal hygiene, germs and their relation to disease, fifteen hours; elementary anatomy, five hours; physiology in relation to its practical application to other subjects, five hours; nutrition and cookery, to include its practical application, twenty hours; general nursing (including the household medicine chest and methods of administering medicine), twenty hours; nursing of children, of the chronic sick, of the aged, and of convalescents, ten hours; emergencies and first aid, five hours; total, eighty hours.

Be it further resolved: That it shall not be the policy of the league to initiate such training of attendants, but that when help is asked by other organizations, the preceding outline be presented as a basis for operation.

Information Bureau of the Red Cross

The information bureau of the Red Cross has been established in New York as a help for the nurses returning from overseas and for institutions in need of nursing help. Five thousand nurses have already returned from overseas. Each returning nurse receives a circular directing her to the bureau of information. Two hundred and seventy-one organizations have applied to this bureau for help. Of the nurses who have applied, 117 have been directed to public health work, 138 to visiting venereal disease work, to tuberculosis, Red Cross, Public Health Service, maternity, and mental hygiene work.

It has been impossible in this brief space even to abstract all of the valuable papers presented, but we hope to present some of them later.

* * * *

Rank for Army Nurses

At a recent meeting of the Santa Clara County Nurses' Association, San Jose, Cal., a resolution was adopted endorsing the conferring of rank upon army nurses and the reorganization of the Army Nurse Corps upon a sound basis to insure to its future members the respect, honor, and dignity already accorded British nurses. A copy of the resolutions was sent to the President and Secretary of War, as well as to the Senate and House of Representatives.

* * * *

Courses in Public Health

One of the most vital problems of the present moment to be met by the nation is the proper care and conservation of public health. This work is being assumed, with the sanction and support of the government, by the National Organization for Public Health Nursing, and Miss Ella Phillips Crandall, executive secretary, plans to organize the nursing forces of the country so as to have a public nurse at the head of each county for the education of the public in matters of health and hygiene. In response to her appeal that university women take up this work as a profession, the University of California offers the following courses: Principles of Public Health Nursing; the Field of Public Health Nursing; Social Problems in Public Health Nursing; History of Public Health Nursing; and Epidemiology for Public Health Nurses. The courses are offered to women already trained as graduate nurses and as elective courses for upper division students.

* * * *

University of Minnesota Public Health Nursing Course

The four months' course in public health nursing, which was given from November 1 to March 1 at the University of Minnesota, was found so successful that a similar course, to end July 1, immediately followed upon its completion. Thirteen graduates or senior nurses-in-training of accredited nurses' training schools finished the course, held under the supervision of the University Medical School and the Minnesota Public Health Association. The Minnesota Public Health Association elected the candidates to the course and paid four-fifths of their tuition fee. Responsibility of securing positions for those graduates of the course who have no definite plans has been assumed by the Minnesota Public Health Association.

QUERIES AND ANSWERS

Charitable Hospital Not Liable for Negligence of Employees

To the Editor of THE MODERN HOSPITAL:

"Please give me some information. This hospital is owned by the county. Because it is the only hospital in the city, we accept pay and part-pay, as well as indigent patients, but we make no profit on these cases. Our yearly report shows approximately 25 per cent strictly charity cases, and a number for which not enough was paid to cover expenses. We receive no charitable contributions or other outside aid.

"A short time ago, a patient became blistered on the buttocks and thighs through the accidental expulsion of a proctoclysis while she was semi-conscious. The patient's husband now claims $500 damages, which in my opinion is extortionate. The county commissioners have offered to pay for the extra treatment necessary to the amount of $150.

"I am anxious to learn the position of the hospital in case a suit is brought against it. Can you cite some decisions that have been made in cases of this nature?

"SUPERINTENDENT OF A COUNTY HOSPITAL."

It appears clearly that our correspondent's hospital is a charitable organization. Certainly it is not run for profit, and the fact that it cares for some part-pay and full-pay patients does not change the aspect of the hospital as a charitable hospital. On this point we may cite the case of the *New England Sanitarium* vs. the Inhabitants of Stoneham, 91 N. E. N. (Mass. 385) in which the court said:

"The dominant purpose for the promotion of which the institution was organized and has been maintained furnishes the test whether it is a charitable or a business organization conducted for commercial gain with incidental acts of charity."

The fact that a patient is a pay patient does not change the aspect of the case, as was shown in the case of Powers vs. the Massachusetts Homeopathic Hospital, 109 Federal Report 294, in which a pay patient in a charitable hospital sued for damages for negligence. The court settled the question whether the fact that a complainant was a pay patient changed the aspect of the case in the following words:

"In our opinion the difference is immaterial. As has been said, the defendant was a charitable organization, that is, a corporation organized exclusively for charity. That the ministration of such a hospital should be conducted exclusively for the indigent is not usual or desirable. Those of modest means from necessity and not a few rich people from choice resort to great charitable hospitals for treatment, especially in surgical cases."

Further, the court said: "In our opinion a paying patient in the defendant hospital as well as a non-paying patient seeks and receives services for a public charity."

From these decisions, which represent practically unanimous opinions of the courts in this country, it appears that our correspondent's hospital is a charitable hospital and that damages cannot be claimed so long as the hospital exercises reasonable care in the selection of assistants and attendants. We assume, of course, that the offer of the county commissioners to settle for $150.00 was not a recognition of legal liability but a further extension of the charity in providing the medical treatment required in the particular case. It hardly seems possible, therefore, that the complainant would have any sort of a case unless there are some peculiar provisions of the state laws with which we are not familiar.

The Most Serviceable Style of Hospital Windows

To the Editor of THE MODERN HOSPITAL:

"Is the double-hung sash as serviceable a hospital window as can be obtained? What are the objections to the casement window? What, in your opinion, are the characteristics of an ideal hospital window?

"HOSPITAL SUPERINTENDENT."

An ideal hospital window should have a durable frame, should be simply constructed, should be weather-tight, should permit of some direct ventilation without creating disagreeable drafts, should permit of cleaning from the inside (reversibility), should permit of various degrees of opening (up to 100 per cent for ventilation in summer), should have a minimum number of subdivisions or sections (thus affording maximum transparency), should permit of the ready application of fly-screens, should not interfere with the convenient operation of awnings, shades, or curtains; and the window, when open, should not extend so far into the room as to interfere with the free use of the room space.

I know of no hospital window which fully meets all of these requirements, but inasmuch as some of the characteristics which are called for seem to be mutually exclusive, this is not altogether surprising. There are a number of excellent windows on the market which would score fairly high on a scale based upon the requirements enumerated above.

S. S. GOLDWATER.

LETTERS TO THE EDITOR

Washing Spots from Soiled Linen

To the Editor of THE MODERN HOSPITAL:

"All spots must be washed off all linen before it is thrown down the chute" is certainly a *dangerous*, filthy, disagreeable, unnecessary practice. Just think of the inconsistency of having the nurses handle all pus linen (for instance, binders from empyema cases) with forceps in the patient's room and then take it to the hopper and wash that, as well as any linen stained by blood, fecal matter, vaginal discharge, etc., by hand!

Why can't all such linen be collected in large cans on the floors, and taken to the laundry at stated intervals? There a washer could be set aside and used to soak and wash out, in cold water, such material before it goes into the general laundry. Or the hospitals who are still foolish enough to send their linen to a commercial laundry could keep an ordinary washing machine in their service room, and, since most hospital superintendents seem to think that all disagreeable work must be done by nurses, assign a nurse at the time to do this by a more sanitary method. The present method, I am sure, is responsible for many infections.

FORMER HOSPITAL SUPERINTENDENT.

The American Red Cross has appropriated $65,000 to enable the American Women's Hospital Association to send a mobile hospital unit to Serbia for relief work in connection with typhus and other epidemics. Of this amount $25,000 is a cash donation, the balance representing supplies to be provided from existing stocks in Europe.

DISPENSARY AND OUT-PATIENT WORK

Conducted by MICHAEL M. DAVIS, Jr.
Director of the Boston Dispensary.
Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

THE SOCIAL WORKER AS CLINIC EXECUTIVE

Clinic Executive a Humanizing Element of the Dispensary Organization—Must Be Temperamentally Fitted for Her Work—Social Service Experience More Important Than Medical

By BERTHA CHACE LOVELL, Boston Dispensary, Boston

In a paper in the June issue of THE MODERN HOSPITAL, I attempted to define the functions of the clinic executive. I represented her as absorbed in the job of keeping the patient and the doctor together until such time as the former had no need of the latter's services and accomplishing this rather difficult, though far from thankless task, by making both doctor and patient feel that the clinic was satisfying the demands that each made upon it.

A chance to devote himself to the diagnosis and treatment of the patients who need him, with no exasperating hitches and halts in the machinery of clinic administration and no unnecessary interruptions by people he doesn't want to see; a chance, too, to find out more about a patient's medical and social background than he can learn in a hurried first interview—these are the doctor's demands. The patient's demands bulk larger—"ordinary creature comforts in the building itself, no exaggerated waits in the ante-room of the clinic, a square deal as to the order in which he is admitted to the doctor, an understanding of the medical situation that meets his intellectual and emotional needs, such arrangements as to payment or non-payment of fees as can be fitted into his scheme of life, and a firm but persuasive hand stretched out from the clinic to draw him back if he stops his treatment too soon."

The clinic executive, therefore, must juggle with many balls and must keep them all from falling. If creature comforts are lacking and if the patients wait each day for hours in the ante-room before they are treated, the clinic executive will have something to report to those whose actions will alter conditions. If the clinic machinery is rusty or broken, she can oil or mend it. If people outside the clinic and within it need explanations and interpretations that mean much of repetition, and much, very much of patience and understanding, the clinic executive can generally send them forth content.

She writes letters about patients and to them. She takes social histories. She knows which man should be urged to pay out-patient fees and which woman should be given car fares home. She sees that an urgent reminder reaches every patient who stays away from the clinic without known cause and that no one who has returned because of such a reminder leaves the clinic without a chance to tell his story. If his story—if any story she hears—seems to her to indicate that the patient is in special need, whether it be of food or of a new viewpoint on life, she attempts to find out how it can best be met.

The question as to who the clinic executive shall be—whether she shall have special training for her job, in other words—is coming to be a very pressing problem.

There are three groups which might presumably be drawn upon for candidates, women with secretarial training and experience, public health nurses, and medical social workers. It is evident that all these groups could furnish clinic executives who would qualify well for certain aspects of the job.

The trained secretary would be especially well fitted to attend to the machinery of the clinic organization. She knows how to file and how to classify. She understands the latest and best methods of bookkeeping. She could install a system of "follow-up" which would be reliable and at the same time easy to operate. Her statistics would be accurate.

Into the question of human relationships, however, the relation, for example, of one individual to another, or of an individual to his own physical handicaps, the secretary's training has not carried her far. The danger would lie in her tendency to feel that the aim of the clinic was realized, as far, at least, as her connection with it was concerned, with the achievement of a smoothly running machine.

The public health nurse would unquestionably have advantages from the medical point of view. She comes from the hospital with a very real working knowledge of physiology and hygiene and a helpful understanding of the use of drugs, of the significance of various diseases and physical maladjustments, and of the procedure of treatment commonly employed in handling them. She is accustomed to deal with sick people. Her special technique, however, a technique which in certain aspects at least is difficult of execution and acquired only by long practice, she will have no chance whatsoever, as clinic executive, to put to use. She has no need of sponge or syringe or scalpel. She will not wait—except in a neighborly fashion—upon either doctor or patient. It is her knowledge of the after effects of typhoid fever that will count in her favor, not her deftness in administering a typhoid bath. She need not know the difference between a tenaculum and a pipet. The position of clinic executive, that is, does not offer her a field in which her own peculiar skill can find even a limited expression.

The chief function of the clinic executive is a social one. She is primarily a social diagnostician, a social practitioner, and a social interpreter. Unless she has had thorough training in the technique of social work and is well grounded in what might be called the social worker's "materia medica"—the knowledge, that is, of the social resources that can be tapped in a community for the benefit of the individual or group—how can she adequately fulfill these functions? How can she attempt to deal with the problems of character, of heredity and environment, unless she has been guided by wise teaching towards some vital understanding of the principles that underlie these problems?

The clinic executive must be a thinker, for she is a co-worker with the doctor. As he initiates in his line, so does she in hers. As he makes use of his technical skill, gained by experience, his knowledge of the significance of presenting mental and physical symptoms, his judgment as to the urgency of action in a given case, and the right method of treatment to pursue, so must she make

use of her own knowledge and judgment in another field. Both will need imagination and insight, for they are dealing with human beings. Both will need a scientific viewpoint, for they are pledged by the very nature of their work to seek out the truth without prejudice and without fear of bringing unwelcome facts to light.

As social diagnostician, the clinic executive studies both the clinic as a whole and the individual patient; for clinics, as well as patients, have their own individualities. They have atmosphere, they have morale. They wilt, or they stimulate. They are confused and rumble with a suppressed resentment or they are centers of enlightenment as well as of healing. The clinic executive will be aware of the special pitfalls her own particular clinic presents; in one perhaps it will be the tendency toward a certain looseness of speech among the patients on the waiting benches, in a second the disposition on the part of a late comer to steal the turn of a patient who arrived earlier. Whatever it may be, to the clinic executive it will seem worthy of consideration.

Almost as significant a symptom, however, of the morale of the clinic as the tone of the waiting room, is the increase or decrease in the average number of visits per patient and the rise or drop in the number of patients who are lost from the clinic without known cause. The clinic executive needs not only to understand how to keep statistics, but she needs to know what statistics to keep, *and how to pluck their meaning from them,* so that she can size up her problem and determine in what sector her next drive must be made. She will learn, for example, what group of patients need home visits before they become regular in their attendance at the clinic, and how the patients who are being sent in by outside social agencies compare with the patients who come to the clinic of their own accord in regard to the rate at which they drop out of the clinic. Figures, figures rightly interpreted, will give her a basis for action.

If the clinic executive has really "made good" in her work and has won the confidence of the chief of the clinic, she will, no doubt, get from him considerable insight into many of the deeper problems of clinic organization and can share with him his hopes for clinic expansion and development. Knowing what phases of clinic activities he wishes to have emphasized she can use her influence intelligently in those directions.

Quite as important as the clinic executive's study of the clinic as a whole, is that of her function as social diagnostician for each and every patient in the clinic for whom she assumes responsibility. To this she must bring whatever of art and skill as social worker she possesses.

Much of her diagnosis is necessarily based upon surface symptoms. She will be liable to frequent error. But like the dermatologist who sees a small skin sore and calls it a pustule of chicken pox, then sees another and calls it a primary lesion of syphilis, she will distinguish between the slight and temporary social disability and the situation that can only be remedied by drastic measures. She will know, as does the dermatologist, that certain diagnoses need to be confirmed by further tests or investigations, and the greater her skill, the greater will be her use of all the aids the social resources of the community can offer.

There are four groups into which the patients she is supervising will fall: (1) those that need no services other than the routine services of the clinic; (2) those that need special attention only when an unusual problem arises; (3) those that need to be closely watched throughout treatment; and (4) those that need more exhaustive study and constructive action than the clinic provides opportunity for. These groups are inevitably in flux. Patients from Groups 1, 2, and 3 may any day shift into Group 4 and later come back into their original place. It is only by knowing each patient's problems as best she may and being always on the alert for self-revelations by word of mouth and for symptomatic behavior that she can hope to discover the patients who are most desperately in need of social service help.

Her vigilance must be never-ending, for, in any but a very small clinic, it is only an inconsiderable proportion of the patients who can have the benefit of a searching study of their social problems. The clinic executive realizes that the amount of work she can do will always fall far short of that which should be done. She does not attempt to scale the infinite. She tries to select wisely. The important fact is this—if she is a well-trained social worker, she will often recognize from symptoms that to an untrained worker might be of no significance, an arresting situation.

After she has made a social diagnosis, the clinic executive acts upon it. Both within and without the clinic she functions as social practitioner. Typical of the problems she is called upon to meet within the clinic is that of explaining to a patient why a piece of orthopedic apparatus may be worth what seems to him a prodigious sum of money, and the need, just as imperative, of seeing that he returns to the clinic to have the apparatus inspected and adjusted as often as the doctor considers necessary. Or she may decide to refer to a child-placing agency a woman who should undergo a surgical operation but hesitates because her children have no relative with whom they can stay in her absence.

Necessarily much of her treatment within the clinic will be by nothing more tangible than words. If, however, "human nature is sure one hundred per cent psychology," the value of the clinic executive's accessibility whenever trouble is brewing on a patient's horizon is very great. Particularly is this so if she happens to be open-minded, intelligent, sympathetic, and resourceful. The center of many a problem, especially in a nerve clinic or in a clinic for the treatment of one of the venereal diseases, is a distorted point of view.

The clinic executive can be of very real assistance to the patient who, while under the supervision of a social worker outside the clinic, is taking clinic treatment. The clinic executive can both talk and listen, and will often get interesting side lights on a social situation that the outside worker is lying awake nights to solve. It may easily happen that a patient who is labeled "uncooperative" in a relief agency may be revealed as only unusually slow of comprehension, or perhaps as intent on shielding an erring member of her family whose story she can first bring herself to tell in the medical atmosphere of the clinic.

A most important form of clinic treatment, depending directly, in every case, upon the social diagnosis she has made, is, of course, the clinic executive's decision as to whether or not the patient can meet the clinic fees. Without regular attendance at the clinic the patient's chances of recovery, are, in most instances, diminished, and his attendance is admittedly influenced by the state of his pocketbook.

Not the least of the clinic executive's duties within the clinic is the ever-present task of writing letters to delinquent patients. Even though her letters generally bring a high percentage of returns because they are written, in every instance, to one whose circumstances

she knows, there are times when she must resort to a "follow-up" call. Her calls on patients remiss in their attendance represent practically her only function without the clinic. It is one that she is especially qualified to fulfill, however, if she is a trained social worker whose experience has included many home visits of a great variety of types. I should even go so far as to advise that every clinic executive have some time allotted for intensive case-work on a small group of cases, so that she may study at first hand into some of the most baffling of the problems of personality and of environment that force themselves into her day's work. To do the most effective work within the clinic she must keep in close touch with the homes her patients come from, and the people her patients live among. She needs to pit her skill, at least occasionally, against all phases of a problem, no matter in what guise it presents itself and however far it may lead from the clinic.

However, for the main bulk of her intensive case work, she will always have to depend upon some worker either inside or outside the clinic who is devoting herself to that particular type of social work.

As a social interpreter the clinic executive again relies on her training and experience as a social worker. An interpreter must not only speak two languages; he must be an adept in both. He must be able to distinguish even the finest shades of meaning.

Since the clinic executive speaks the language both of the clinic and of the social service agency, she, better than any one else, knows what the social worker outside the clinic needs to obtain from the doctor in the way of fact and opinion. She can receive it from him with the minimum expenditure of time and effort. Her version of it is, or should be, correct. On the other hand, she has learned to distinguish between the kind of social facts the doctor wishes to know—or may profit by knowing—and those that do not concern him, and can present her facts to him in a telling manner, from whatever source she has gleaned them.

The clinic executive acts as an interpreter also between the patient and the hospital or out-patient department. She is in the institution, and yet, in a very real sense, not of it. It is the chief of her qualifications perhaps that she is non-institutionalized. She knows the organization of the institution, she understands its rules and regulations, and the necessity for their formulation. But she has as well a very conscious loyalty to the interests of the individual patient. While she cares very sincerely that the clinic shall run in such a fashion that its standard of medical and nursing service rank high, she cares equally that Mr. A and Mrs. B be considered as personalities who differ in tradition, in race, and in social status, and who cannot be treated as automatons of identical figure without serious risk of thwarting the end for which the institution exists—the public good. She can be counted upon as a dependable aid to all the forces within the hospital or out-patient department that are working to keep the institution human.

Where, then is the clinic executive to be found—the clinic executive who is social diagnostician, social practitioner, and social interpreter, and who has, besides, such knowledge of the significance of physical disability and physical well-being in the life of the individual and the community that she can function as an intelligent factor in an out-patient clinic? A certain number will undoubtedly be drawn from the ranks of those trained social workers who have acquired, as part of their training, a clear understanding of some of the most important social aspects of medicine. The opportunities to acquire this type of training are increasing, as the need for medical social workers becomes increasingly apparent. The schools for social work and philanthropy are now including in their curriculums lectures and even, in some instances, definite courses in social medicine, and are providing opportunities for observation and practice work in clinics and hospitals. The fact that the graduates of these courses are still few in number does not mean that the movement is insignificant. If, however, the choice must be made between a clinic executive who lacks medical knowledge and a clinic executive who lacks social understanding and vision, it seems essential that that worker be chosen who can truly be called a *social* worker.

JANE DELANO, R.N.—AN APPRECIATION*

With a Mother-Heart, Working Ever for "Her Boys" and Working to Win the War, Her Last Words Were, "I Must Get to My Work"

By CHARLES A. DREW, M.D., Superintendent, Worcester City Hospital, Worcester, Mass.

On the fifteenth day of last April, Jane A. Delano died in Savigny, France. I never saw Miss Delano to know her. But I do know that in her the nursing profession of America lost one of its most honored members.

To a sister nurse who stood by her side as she was recovering from ether given for a fourth operation on a suppurating mastoid, Miss Delano said, "But what about my work? I must get to my work." These were her last words. We never heard that Jane Delano was a saint. She doubtless had her faults and limitations. Had she been perfect she would not have been interesting to us. Her mind was not much concerned with the thought of death which she must have realized was dangerously near.

Nurses and doctors are not good patients as a rule—they know the danger signals too well. The heart of Jane Delano was still with her work. Working for "her boys" and working to win the war. All the honors she could hope for had been hers. It was not of honor and fame she was thinking, but of her work which to her was the greatest thing on earth.

Was it wise for Jane Delano to be so absorbed in her work? It seemed to some as if she had so glorified her work as to make it her religion. Was this the highest wisdom? We do not venture to judge. One's viewpoint would depend on his conceptions of the work and his notion of religion. Jane Delano in the last hour of her life was thinking, not of her soul's salvation but of her work, and her work was largely the helping and saving of others.

Was it wise for Jane Delano to give to her work the devotion she might have lavished on husband, home, and children? She was physically and mentally beautiful in her young womanhood and to some, even more beautiful when her hair was white. Many have said: "What a noble mother she might have been!"

Jane Delano spoke often of the suffering of "her boys" in France with moist eyes. The mother instinct would claim its own. The mother-heart beat just as warmly for "her boys" as if they had been, indeed, of her own blood. It was largely her nature, but partly her whole-souled devotion to her work that made her what she was.

I want to leave the thought of Jane Delano and her work in the minds of those who may follow her as my contribution to your memory of this evening.

*Address to the Graduating Class, Training School for Nurses, Worcester Hospital, June 17, 1919.

BULLETIN OF THE AMERICAN HOSPITAL ASSOCIATION

Offices:
728 Seventeenth Street, Washington, D. C.
308 Anisfield Building, Cleveland, Ohio
Monthly Bulletin issued by the Executive Secretary
308 Anisfield Building, Cleveland, Ohio
HOWELL WRIGHT Executive Secretary

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Dr. Robert J. Wilson
Mr. Howell Wright, Secretary

No hospital in the country can afford to miss being represented at the coming meeting of the American Hospital Association. It is the first meeting held after the adoption of the hospital membership plan; it is the first meeting held after the end of the war. It is to cover an exceedingly wide range of most practical and vital topics, of interest to public health officials as well as to hospital trustees, superintendents, superintendents of nurses, dietitians, stewards, and social workers. These topics include hospital standardization, the proper relation between the state and private hospital, workmen's compensation, and sickness and health insurance, and their relation to the hospital, every-day problems of hospital construction and administration, training of pupil nurses, increased cost of food and food service, out-patient and other extension work. In addition to the non-commercial and commercial exhibits, there will be an architectural exhibit, at which plans and models will be shown and talks given by well-known hospital consultants. The president and secretary have issued the following call:

"To the Trustees and Managers of American Hospitals:

"Your cooperation is needed in an organized effort to work out the 'every-day' and 'after-the-war' problems which now face American hospitals. Hospitals, as other industries, must pass through this period of 'reconstruction.'

"During the war the hospitals of America performed important services. They served as emergency stations in demobilization and transportation of troops; performed various corrective operations making men eligible for service; assisted recruiting officers in determining exact physical condition of applicants for enlistment; they contributed to the problem of providing medical assistance to the families of men in the service; undertook to train increased numbers of pupil nurses; *they willingly submitted to the wrecking of organization by the fact that the greater number of their staffs, interns, and graduate nurses entered the service.* Hospitals must recover and advance.

"'Hospital standardization' is dominant in the hospital mind today. Distinct progress with this problem must be made *now*. The service of hospitals to public health is another problem. Did the hospitals meet the demands of the public in the recent influenza epidemic as they should? If not, what is wrong? What is the proper relation between the state and the private hospital? Workmen's compensation is now before many hospitals and is often a problem. Sickness and health insurance will soon follow. There are also the 'every-day' problems of hospital administration, hospital construction, out-patient work, the training of pupil-nurses, the problem of the present increased cost of food and food service. There are many others. They must be met. Many of them can be solved only by state- and nation-wide hospital organization.

"Institutional membership in the American Hospital Association provides a nation-wide organization with other hospitals and an opportunity to participate in the activities of the Association. *You are urged to participate as an institutional member* and to make use of the enclosed application blank. Advantages of this membership are emphasized in the enclosed editorial. Whether your hospital is now, or becomes, a member of the association or not, *you are urged to send your representatives* to the twenty-first annual convention, September 8-12, 1919, Cincinnati, Ohio. Participation in this meeting will demonstrate the full value of institutional membership to your hospital.

"Please communicate with the secretary for further information.

"For the American Hospital Association,
"HOWELL WRIGHT, Executive Secretary. A. R. WARNER, President."

That the convention will be made welcome by the city of Cincinnati and the local hospital profession is evident from the following letters of welcome from Mayor Galvin and Major Holmes, the chairman of the local committee of arrangements:

"To the Members of the American Hospital Association:

"Understanding that your convention is to be held in our city during the week of September 8-12 of the present year, as the chief executive of the city, I wish to extend to each one of you a most hearty welcome, and to let you understand that our citizens generally greatly appreciate the fact that your annual gathering is to be held here with us.

"I feel that you will not regret for a moment that your organization decided upon the Queen City for their place

AMERICAN HOSPITAL ASSOCIATION

Twenty-first Annual Convention

(The American Dietetic Association meets jointly at its second annual convention with the American Hospital Association.)

Headquarters—Hotel Gibson, Cincinnati, Ohio.
September 8-12, 1919.

PURPOSE

This convention is intended to be of practical value to the Public Health official as well as the hospital trustee, superintendent, superintendent of nurses, dietitian, steward and social worker.

Practical, "every-day" as well as "after-the-war" hospital problems will be discussed and considered. No American Hospital should be without representation at this meeting.

QUESTIONS AND ISSUES TO BE DISCUSSED AND SETTLED

Did the Hospitals meet the demands of the public in the recent influenza epidemic? If not, what is wrong?

Hospital Standardization (the dominant problem in the hospital mind today). Something must be done about it now. What shall it be? How shall it be done?

What is the proper relation between the state and the private hospital? State and nation wide hospital organization.

Workmen's compensation and the hospitals. Sickness and health insurance.

The "every-day" problems involved in—
- Hospital Construction
- Hospital administration
- Training of pupil nurses
- Increased cost of food and food service
- Out-patient and other extension work.

IMPORTANT EXHIBITS

ARCHITECT'S EXHIBIT. It will show plans, sketches, blue prints, pictures, models. There will be practical talks on hospital construction by well-known hospital consultants.

NON-COMMERCIAL EXHIBIT. Hospital forms, records, etc. Hospital economies and hospital methods.

COMMERCIAL EXHIBIT. The Association will have its largest hospital commercial exhibit.

Make your Hotel Reservations Early. For additional information write the Secretary.

AMERICAN HOSPITAL ASSOCIATION,
308 Anisfield Building, Cleveland, Ohio.

of gathering, and there will be a warmth of hospitality extended to you, such as I believe you will appreciate and enjoy.

"We are honored to have you as our guests.

"Come to us at as early a date as you can, and stay here as long as your business and other engagements will permit.

"Very respectfully,
"JOHN GALVIN,
Mayor."

"Members and Friends—American Hospital Association:

"As chairman of the Cincinnati committee on arrangements for the annual meeting of the American Hospital Association, which comes to Cincinnati September 8 to 12 I extend to you a cordial invitation to be present at the meeting which we hope to make the greatest in the history of the organization.

"We are proud to have the members of the American Hospital Association as our guests. We want you to come here and have a beneficial and pleasant visit with us. We want you to carry away a good impression of the Queen City.

"The Cincinnati committee on arrangements will spare no effort to make your stay here one long to be remembered and we sincerely hope that the members of the association will attend in large numbers.

"While here we want you to see our many spots of interest. Naturally, we are anxious to have you visit our general hospital and have arranged to have the sessions on one day of the meeting held at the hospital to give the members an opportunity to inspect it thoroughly. We feel sure that this visit to the Cincinnati General Hospital alone will be worth the effort you may make to attend the convention.

"We don't want you to rush in and rush out. Come to Cincinnati early and spend as long a time as possible with us.

"Again bidding you a most hearty welcome to the Cincinnati convention, I am,

"Sincerely yours,
"C. R. HOLMES,
Chairman."

Tentative Program, Twenty-first Annual Convention, American Hospital Association; Second Annual Convention, American Dietetic Association

General sessions and the majority of the section meetings will be held in the Hotel Gibson. Section meetings will also be held in Hotel Sinton, across the street from the Hotel Gibson, and at the University of Cincinnati Medical School and Cincinnati General Hospital. Complete program will appear in the Pre-Convention number of THE MODERN HOSPITAL (September). It will include the place and number of the hall or room assigned for each meeting.

MONDAY, SEPTEMBER 8

AFTERNOON, 3 P. M.

Registration.

EVENING

Informal gathering, music, inspection of exhibits.

TUESDAY, SEPTEMBER 9

MORNING, 10 A. M.

General Session

Formal opening of the convention.
Major C. R. Holmes, chairman of the local committee, presiding.
Address of welcome, The Mayor of Cincinnati.
Address, The Governor of Ohio.
President's Address, Dr. A. R. Warner, President.

AFTERNOON, 2 P. M.

Section Meetings

Section on Out-Patient Work, Mr. Michael M. Davis, Jr., Chairman.
Subjects for Papers and Discussions (speakers to be announced):
- Clinics for Venereal Disease.
- The Work of the Catholic Hospital Association in Connection with Dispensaries.
- Dispensaries and Health Insurance.
- Round table discussions of points raised by members of Section.

Section on Hospital Construction, Dr. George O'Hanlon, Chairman.
- Fire Hazard in Hospital Buildings—Extent and Remedial Measures, Mr. W. D. Crowe.
- New Features of Hospital Building Equipment, Mr. E. F. Stevens.
- When to Plan and When to Build, Mr. Wm. O. Ludlow.
- In Planning a Hospital, Build with Reference to Its Future Development, Mr. Oliver H. Bartine.
- Discussion, Miss Jean Allison Hunter, Grace Hospital, New Haven.
- Departmental Division of Heat, Light, and Power Costs, Mr. D. D. Kimball, Dr. H. M. Pollock.

Section on Nursing, Miss Elizabeth A. Greener, Chairman.
Subjects for Papers and Discussions (speakers to be announced).
- The Nursing Situation from the Standpoint of the Large University Hospital.
- The Nursing Situation from the Standpoint of the Medium-Sized Hospital Without University Connections.
- The Nursing Situation from the Public Health Point of View.
- The Nursing Situation with Regard to Future Military Nursing Needs of the Country.

Section on Dietetics, Miss Lulu Graves, Chairman.
(See Program of American Dietetic Association.)[1]

EVENING, 8 P. M.

Reception and Inspection of Exhibits.

WEDNESDAY, SEPTEMBER 10

MORNING, 10 A. M.

General Session, Subject, Hospital Standardization.
Joint Session of the American Hospital Association and American Conference on Hospitals.

AFTERNOON, 2 P. M.

General Session.

Joint session of the American Hospital Association and American Conference on Hospitals.

EVENING, 8 P. M.

Special meeting for state delegates appointed by the governors, prominent governmental official presiding.

Special Subject: Hospitals and the State.

(Speakers to be announced.)

1. Present Relations Between Hospitals and the State Governments.
2. Did the Hospitals Meet the Demands of the Public in the Recent Influenza Epidemic?
3. What Is the Proper Relation Between the Hospitals and the State?
4. Workmen's Compensation and the Hospitals.
5. Sickness and Health Insurance and the Hospitals.

THURSDAY, SEPTEMBER 11

MORNING, 9 A. M.

Visit to Cincinnati General Hospital and University of Cincinnati Medical School.

10:30 A. M.

Section meetings at the Medical School and the Hospital.
Section on Social Service.
Section on Dietetics.
(See program of the American Dietetic Association.)[1]
Section on Hospital Administration.

AFTERNOON, 3 P. M.

Special round-table meeting under the direction of Mr. Asa S. Bacon, presiding.

EVENING

No schedule.

FRIDAY, SEPTEMBER 12

MORNING, 10 A. M.

General Session.

Joint Session of the American Hospital Association and the American Dietetic Association.

AFTERNOON, 2 P. M.

General Session.

Reports of committees.
Election of officers.
Other business of the association.

EVENING

General Session.

Adjournment dinner, special program of speakers.

Plans for Architect's Exhibit

Plans for a really splendid, instructive, and profitable display and symposium on hospital plans and principles of construction, for the Cincinnati Convention, are now practically completed and they assure one of the most interesting and instructive features that we have ever had at any hospital convention.

Ample space (708 square feet) in the form of a large room (Room D, Mezzanine floor, Hotel Gibson) has been set aside for this particular display and the physical arrangement will be such that plans can be shown by classes of hospitals.

The arrangement contemplates division of plans into the following classes: (1) large general hospital groups; (2) medium-sized general hospital groups, approximately 150 beds; (3) small community general hospitals; (4) isolation hospitals; (5) isolation units in general hospitals, large and small; (6) venereal hospitals; (7) venereal units in general hospitals; (8) maternity hospitals; (9) maternity units in general hospitals; (10) tuberculosis hospitals; (11) tuberculosis units in general

[1] The program on Dietetics will be found in the Department of Hospital, Medical and Special Meetings on page 140.

hospitals; (12) children's hospitals; (13) children's units in general hospitals; (14) orthopedic and reconstruction hospitals and units in general hospitals.

It may be desirable, when all plans are in and the exhibit set up, to group each special hospital with the unit of the same character in general hospitals so that the whole subject of that specialty can be discussed in the symposium.

It is thought desirable not to make a definite program as to the times of day and the days upon which talks are to be given on these various architectural and construction problems and that it will be better to wait until the convention opens and then announce by bulletin precisely when the various talks are to be given and by whom.

All the architects who are known to have created really constructive hospital work have been invited to participate in this exhibit, and with the now classified arrangement of the hospitals, attendants at the convention can be present at those meetings that are to discuss the particular subjects in which they happen to be interested at the time.

The convention is drawing rapidly near, and to save time it is desirable that architects who wish to show plans, and superintendents of hospitals who have plans which they think will be of interest and profit and who would be willing to show them in this exhibit, will please communicate directly with Dr. John A. Hornsby, special secretary of the association, who has the exhibit in charge, at his office, Munsey Building, Washington, D. C.

Institutional Membership

Up to date, 147 hospitals have applied for institutional membership. Of this number 126 have been approved by the Membership Committee and membership certificates issued. The following hospitals have applied since the last bulletin was published:

Robert Packer Hospital, Sayre, Pa.
St. Mary's Hospital Corporation, Waterbury, Conn.
Norwegian-American Hospital, Chicago, Ill.
German Evangelical Deaconess, Chicago, Ill.
Rochester General Hospital, Rochester, N. Y.
Protestant Deaconess Hospital, Evansville, Ind.
St. Albans Hospital, St. Albans, Vt.
Montefiore Home, New York, N. Y.
Miami City Hospital, Miami, Fla.
City Hospital, Bellaire, O.
Good Samaritan Hospital, Zanesville, O.
The Swedish Hospital, Minneapolis, Minn.
Sherman Hospital, Elgin, Ill.
The Lawrence and Memorial Hospitals, New London, Conn.
St. Louis Maternity Hospital, St. Louis, Mo.
Saginaw General Hospital, Saginaw, Mich.
Hillsboro Hospital, Hillsboro, Wis.
Cleveland Homeopathic, Cleveland, O.
Fremont Hospital, Fremont, Neb.
Hospital of Woman's Medical College, Philadelphia, Pa.
Springfield Hospital, Springfield. Mass.

Appointment of delegates to represent institutional members.

Every institutional member is expected to appoint three delegates to represent it at the convention. Cards have been sent to all applicants, upon which they have been requested to write the names and addresses of their representatives. A number have not replied. It is important that these names be sent in at the earliest possible moment. There will be special registration for institutional delegates at the convention.

Non-Commercial Exhibit

The following bulletin is being mailed to Institutional Members and others. The Secretary urges hospitals to cooperate with the local committee in making the proposed non-commercial exhibit an unusual success.

The non-commercial exhibit, arranged by a special local committee, is to be one of the features of the twenty-first annual convention of the American Hospital Association, Cincinnati, Ohio, Hotel Gibson, September 8-12, 1919. The exhibit will be arranged in room A on the Mezzanine floor, Gibson Hotel, headquarters. The committee desires your assistance and cooperation. Originality and quality is desired rather than quantity. The following suggestions have been made:

1. Hospital pictures of interest showing both exterior and interior of hospital.
2. Interesting reports and hospital forms and records.
3. New or original hospital devices or apparatus.
4. Economies promoted.
5. Exhibits of forms, reprints and other literature.

Hospital dolls, exhibited to show uniforms, and *nurses' uniforms* are not desired.

Hospitals desiring to exhibit are requested to communicate with the chairman of the committee. *Please reply on the enclosed card.*

COMMITTEE ON NON-COMMERCIAL EXHIBIT,
ALICE THATCHER, Chairman,
Chamber of Commerce, Cincinnati, O.

Commercial Exhibit

The commercial exhibit promises to be the largest the Association has ever arranged. Members are urged to familiarize themselves with the names of the exhibitors before the convention. Special plans are being made to afford ample opportunity for the inspection of exhibits.

COMMERCIAL EXHIBITORS

1919

Room	
II	Meinecke & Co.
III	Simmons Company-Burton-Dixie Corporation.
IV	Thorner Bros.
V	Lewis Mfg. Co.
VI	American Laundry Machine Co.
VII	Coast Products Co.
Space	
101	J. B. Ford Co.
102	Lyon Mfg. Co. Breathing machine.
103	J. B. Lippincott.
104	Born Steel Range Co.
105	Aluminum Cooking Utensil Co.
106	Life Saving Devices Co.
107	Klearflax Linen Rug Co.
108	Becton, Dickinson & Co.
109	Dennison Mfg. Co.
110	Pfaudler Co.
111	Holtzer-Cabot Electric Co.
201-202	Columbus Aseptic Furniture Co.
203	Genesee Pure Food Co.
204-5-6	Max Wocher & Son Co.
207-208	Albert Pick & Co.
209-210	Watters Laboratories.
211	Colson Co.
301	Horlick's Malted Milk Co.
302	Sanitary Cup Co.
303	Randall-Faichney Co., Inc.
304-305	Frank A. Hall & Sons.
306	Brick Sales Co.
307	H. W. Baker Linen Co.
308	Lyons Sanitary Urn Co.
309	B. Lowenfels Co.
310-311	Frank S. Betz Co.
312	Borden's Condensed Milk Co.
313	Safety Anesthesia Apparatus Concern.
401	Randles Mfg. Co.
402	Kimberly-Clark Co.
403	Taylor Instrument Companies.
404	Powell & Giberson Linen Co.
405	Wilmot Castle Co.
406	Takamine Laboratory, Inc.
407	American Sterilizer Co.
408-409	J. L. Mott Iron Works.
410	Hollister-Wilson Laboratories.
411	Bromley-Merseles Mfg. Co., Inc.
412-13-14-15	H. D. Dougherty & Co., Inc.
1-2	S. Gumpert & Co.
3	Thompson's Malted Food Co.
12	Hungerford Smith Co., J.
13	Royal Baking Powder Co.
23	Calumet Tea & Coffee Co.
24	Mellin's Food Co.
9-10	John Sexton & Co.
11	Wagner Mfg. Co.
Table Space	Hospital Management.
	THE MODERN HOSPITAL.
	Social Service Quarterly.

Special Garage Facilities for Motor Parties

Arrangements have been made with the Citizen's Motor Car Company to take care of all automobile parties ex-

pecting to reach the convention city by motor. This garage, one of the largest in Cincinnati, is located at the corner of Seventh and Main Streets, just three blocks from the Hotel Gibson and Hotel Sinton.

Storage charges at this garage are 75 cents for 12 hours or less, $1.25 for from 12 to 18 hours, $1.50 for from 18 to 24 hours. These charges include besides storage such ordinary services as air in tires, water in radiator and the like. An extensive repair department is also conducted by this garage which would be available for those who would need major repairs.

Charges for repairs are in line with other parts of the country.

Special Convention Rates

Delegates can secure rates of one and one-third of the general tariff; that is, they pay full fare to Cincinnati to attend the convention and can secure their return ticket home for one-third of the regular amount of fare. To secure the advantage of this reduced fare, delegates must secure a certificate from railroad officials at the time they purchase their ticket to Cincinnati. This certificate must be signed by an official of the railroad and also by the purchaser, and when the delegate arrives in Cincinnati it must be turned over to some official (who will be designated during the time of the convention) for validation.

Two hundred and fifty such certificates must be turned over to the validation officer before the railroads will grant the reduced convention rates, therefore, all delegates should make it a point to provide themselves with certificates. Delegates taking advantage of the reduced fare are required to return home over the same route used in coming to Cincinnati to attend the convention. They must also arrange their affairs so as to leave Cincinnati within three days after the close of the convention.

Delegates can learn at their local ticket offices at what date the railroad officials will begin issuing certificates with going tickets to entitle them to a return ticket for one-third fare.

These certificates will not be issued to persons purchasing child's half-fare tickets, or clergy, charity, or employee's tickets.

1918 Proceedings

The 1918 Proceedings are now being distributed. A copy is being mailed to all members whose dues are paid up to and including the year 1918. Three copies are being sent to each Institutional Member. These are addressed to the delegates appointed to represent the hospital but in the case of hospitals which have appointed no delegates, three copies are being sent to the hospital direct.

Special Plans for the Care of Catholic Sisters Attending the Convention

Special arrangements are being made for the care and comfort of Catholic Sisters attending the Convention. There are numerous Catholic institutions in Cincinnati in which a number of different orders are represented. Sister Victoria, Superior of the Good Samaritan Hospital, a member of the Local Committee on Arrangements, has kindly consented to assist in making arrangements for Sisters attending from the different parts of the country. Sisters planning to attend should communicate with Sister Victoria, direct.

Distribution of Gauze to the Hospitals for the American Red Cross

STATEMENT BY DR. JOHN A. HORNSBY, SPECIAL SECRETARY OF THE ASSOCIATION.

The American Red Cross has extended the time in which civil hospitals are to apply for participation in the bleached gauze distribution which was outlined in this bulletin two months ago and in accord with which a letter was sent out from the American Hospital Association notifying them exactly what was wanted.

It was decided by the Red Cross that only the live, active and acute diseases hospitals would be given this gauze and 3,089 hospitals were selected to participate in the distribution. It had been felt that every hospital that got a letter offering, free to it, certain quantities of this gauze, would respond promptly, but out of the 3,089 letters sent out, less than 800 hospitals replied. The distribution is now being made by the Red Cross from its various storehouses in the different parts of the country.

There were 27,000,000 yards available, which the Red Cross offered to the civilian hospitals free of any charge except freight bills. The 800 hospitals represent only a small proportion of the number and there will probably be 20,000,000 yards left. If the active hospitals will promptly send their names and the data given below to the Washington office of the American Hospital Association, 728 Seventeenth Street, they can have their share not only of this 20,000,000 yards but of the next distribution which aggregates 22,000,000 yards more.

This was a most wonderfully generous offer of the American Red Cross, the civilian hospitals have been having a hard time during the war and it was believed that they would accept this Red Cross offer in the spirit in which it was made and that they would do it promptly.

The information needed and which must be supplied is as follows:

1. Name, post office, and shipping address of the hospital.

2. Character of the hospital, whether acute or chronic, special or general, and if special, what specialty.

3. The number of beds and of this the number of free, part-pay, and pay beds.

4. The amount of the deficit of the hospital for last year, if any, and a statement as to whether the hospital is a private hospital for profit or "not for profit."

5. How is the hospital supported, whether by endowment, subscriptions, or entirely out of earnings.

6. The amount of bleached gauze that the hospital used during the past twelve months.

The Red Cross requires replies to these questions as a basis for its distribution. Please be as prompt as is possible in furnishing the information if you want some of this gauze.

Woman in the Work of Maternal Aid

M. Flamini, who has had wide experience in children's hospitals, children's dispensaries, and maternal institutions, holds that woman, with her motherly instinct, her sympathy, and her experience, should be strongly represented on all mangaging boards of the various institutions, for pregnant and nursing women and for the protection of babyhood. The city of Rome has at present more than forty of these institutions, but in very few of them have women anything to say in the management. The author holds that in all the large cities of Italy a central board of maternal aid should be established similar to those established for the prevention of tuberculosis. On such a board the physician would be the directive mind, and the women would furnish the heart and the arm. The institution of domiciliary visits should be connected with this work.

Flamini's article on this subject appears in a recent number of the *Policlinico* of Rome.

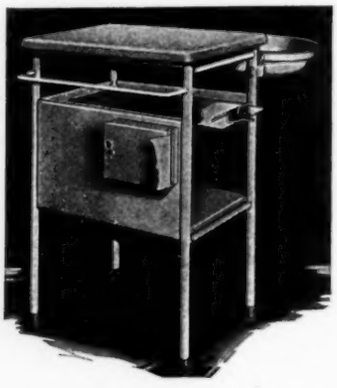
NEW INSTRUMENTS AND EQUIPMENT

VINCENZ MUELLER, Technical Editor,
GEO. W. WALLERICH, Associate Editor,

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast Avenue, Oak Park, Illinois.

A New Bedside Table

A very important sanitary point often overlooked in hospitals is the danger of infection due to using washbasins promiscuously. The accompanying illustration shows a heavily constructed bedside table with a washbasin attached, designed by Dr. E. R. Crew, superintendent of the Miami Valley Hospital. When not in use this can be turned under the top of the table. The table has



A new bedside table with washbasin attached

also an open shelf for the chart file and an enclosed shelf underneath for the bedside accessories which should not be conspicuously displayed. A sanitary toilet-paper holder, white enameled, is placed on the back of the stand Above it the towel rack is shown. The top of the table is made of porcelain-enameled cast iron.

Improved Type of Lamp for Heat Applications

Application of heat is one of the oldest effective remedies, especially in painful inflammations in any part of the body. Heated stones, hot cloths, and hot water bottles of metal or rubber have long been used for this purpose, but at best this could only touch the surface or penetrate into the tissues to an inconsiderable depth.

It remained for the electric light to secure all the benefits that are possible from heat application, and for some years past various types of therapeutic lamps have been on the market.

The new lamp illustrated here is known as the "Sterling" lamp and its construction differs considerably from those offered heretofore. The globe of the lamp burns in a horizontal position in a cylindrical hood made of aluminum, to which a concentrating tube of polished metal may be attached when it is desired to project the rays into the nose, throat, ears, or other orifices.

The hood has a special ventilating device to temper the



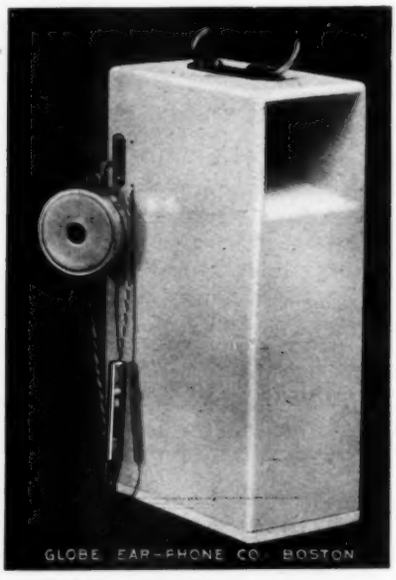
The Sterling lamp

heat and make close and continuous application possible. The lamp is so equipped that it may be attached to any electric light socket. Composition screens of different colors may be fitted to the hood by those who desire the curative properties which are supposed to be inherent to violet, ruby, amber, or green rays.

These lamps are made in four sizes, ranging from 200 to 2,000 candle power.

A Hospital Phone for Deaf Patients

The hospital phone, shown below, is especially valuable in public wards, for it enables doctors, nurses, and visitors to talk freely to deaf patients without disturbing the other people in the ward. It is equipped with a sound regulator which makes it possible to adjust it to all de-



Globe Ear-Phone telephone for the deaf

grees of deafness. The long-life batteries with which it is equipped last from six to eight months without renewing, and the receiver when not in use is suspended on a hook, which automatically shuts off the battery connections.

The instrument is absolutely sanitary, being finished in hard white enamel, with a burnished aluminum receiver and a nickel-plated rheostat.